HOW TO BE A SUPPORT BROKER

AN INSTRUCTION AND PROCEDURES MANUAL

July 2007

www.selfdirection.idaho.gov

Self Directed Community Supports Option

IDAHO DEPARTMENT OF HEALTH & WELFARE

TABLE OF CONTENTS

INTRODUCTION

The guiding Principles of Self-Directed Community Supports Waiver option is that the individuals have:

- FREEDOM to plan their own lives.
- CONTROL over the Medicaid dollars to get the services and supports they need.
- SUPPORT to be involved in their community, as much as they choose.
- RESPONSIBILITY for the choices and decisions they make.

This Manual has several goals:

- Ensure that the potential or working Support Broker understands, agrees with, and can state the philosophy that is the foundation of the Self-Directed Community Supports Waiver option.
- Provide complete step-by-step information describing the Support Broker qualifying process, the function of the Circle of Support and the person-centered planning process and the business model of the Self-Directed Community Supports Waiver option.
- Ensure that the Support Broker knows the required and optional job duties.
- Give the Support Broker the tools, including templates and resources, necessary to do their job.
- Ensure that the Support Broker knows the limitations regarding who can employ them as a Support Broker.
- Give the Support Broker instructions on how to work with their employer and the Circle of Support to complete a Support and Spending Plan.
- Clarify the procedures, processes and rules that govern the role of the Support Broker in the Self-Directed Community Supports Waiver option.

CHAPTER ONE: GETTING STARTED

Support Broker Job Description

A Support Broker is employed directly by a participant with a disability. A Support Broker helps their employer develop and manage their services. They provide support in a way that is flexible, responsive to, and controlled by the individual employer. A Support Broker helps their employer develop their Support and Spending Plan, budget their money, and monitor their community support workers and other paid services.

A Support Broker is committed to a value system that supports each person's fundamental right to live a life of dignity, be fully self-determined, be fully included in community life, and be supported by a network of family members and friends. They help to provide leadership, ideas, commitment, and coordination for their employer. A Support Broker has a clear focus on helping their employers build lives and do whatever it takes to ensure quality in the lives of those they support.

On the Web!
For information about the Idaho Administrative Rules, visit:
http://adm.idaho.gov/adminrules/rules/idapa16/0313.pdf.

The Idaho Administrative Procedures Act (IDAPA) rules are the legal foundation for the state to ensure that the Support Broker adheres to the rules and standards of care for their employer.

According to IDAPA 16.03.13 – *Consumer Directed Services*, at a minimum the Support Broker must:

a. Participate in the person-centered planning process;
b. Develop a written Support and Spending Plan with the participant that includes the supports that the participant needs and wants, related risks identified with the participant's wants and preferences, and a comprehensive risk plan for each potential risk that includes at least three (3) backup plans should a support fail. This plan must be authorized by the Department;
c. Assist the participant to monitor and review his budget;
d. Submit documentation regarding the participant's satisfaction with identified supports as requested by the Department;
e. Participate with Department quality assurance measures, as requested;
f. Assist the participant to complete the annual re-determination process as needed, including updating the Support and Spending Plan and submitting it to the Department for authorization;
g. Assist the participant, as needed, to meet his participant responsibilities outlined in Section 120 of these rules and assist the participant, as needed, to protect his own health and safety;
h. Complete the Department–approved criminal history check waiver form when a participant chooses to waive the criminal history check requirement for a community support worker. Completion of this form requires that the support broker provide education and counseling to the participant and his circle of support regarding the

risks of waiving a criminal history check and assist with detailing the rationale for waiving the criminal history check and how health and safety will be protected.

In addition to the rules stated above, IDAPA requires that each Support Broker must be able to provide the following services when requested by the participant:

a. Assist the participant to develop and maintain a circle of support;
b. Help the participant learn and implement the skills needed to recruit, hire, and monitor community supports;
c. Assist the participant to negotiate rates for paid community support workers;
d. Maintain documentation of supports provided by each community support worker and participant's satisfaction with these supports;
e. Assist the participant to monitor community supports;
f. Assist the participant to resolve employment-related problems;
g. Assist the participant to identify and develop community resources to meet specific needs.

The Application Process

Who Can Apply

The Support Broker application can be found in *Appendix A.*

Q: Who can apply to be a Support Broker?
A: Anyone who believes they meet the minimum qualifications can apply to be a Support Broker.

Minimum Requirements

Individuals interested in becoming a Support Broker must complete the Department approved application to document that they are:

- Eighteen (18) years of age, or older.
- Have skills and knowledge typically gained by completing college courses, community classes, or workshops that count toward a degree in the human services field.
- Have at least two (2) years of verifiable experience with the target population, and knowledge of services and resources in the developmental disabilities field.

You are not eligible to become a Support Broker for a participant if:

- You are the participant’s guardian, payee, or conservator.
- You are the participant’s parent.
- You are the participant’s spouse.
- You are employed by an agency that provides paid community supports to the participant.

Wages

Maximum salary rate for a Support Broker is up to $18.72/hour, but employers are advised to offer less than this to start so they can offer raises. Be sure to discuss your goals and your future with your employer in terms of this financial concept.

Criminal History Check

According to IDAPA rules (16.05.06.015 – 034), the Department of Health and Welfare has the responsibility to ensure criminal history checks are conducted for Medicaid community support workers and vendors. The intent of these rules is to facilitate the protection of children and vulnerable adults by requiring criminal history checks of persons providing care, services, or assuming responsibility for these participants. The Medicaid Central Office Bureau of Developmental Disability Services will ensure that applicants meet criminal history check requirements prior to qualifying an applicant to become a Support Broker and approving service provisions.

Individuals that have any felony convictions or are a party to a valid child or adult protection complaint, cannot work, provide service to, or have any unsupervised contact with Self Directed participants unless an exemption is granted. Individuals convicted of other crimes will be evaluated on a case-by-case basis and may be granted an exemption.

No exemption will be granted for the crimes listed below:

- Armed robbery.
- Arson.
- Crimes against nature.
- Forcible sexual penetration by use of a foreign object.
- Incest.
- Injury to a child, felony, or misdemeanor.
- Kidnapping.
- Lewd conduct with a minor.
- Mayhem.
- Murder in any degree.
- Voluntary manslaughter.
- Assault or battery with intent to commit a serious felony.
- Poisoning.
- Felony involving a controlled substance within seven (7) years of the date of conviction.
- Possession of sexually exploitive material.
- Rape.
- Felony stalking.
- Sale or barter of a child.

- Sexual abuse or exploitation of a child.
- Any felony punishable by death or life imprisonment.
- Any felony involving any type or degree of embezzlement, fraud, theft, or burglary within seven (7) years from the date of conviction.
- Abuse, neglect, or exploitation of a vulnerable adult.
- Attempt or conspiracy to commit any of these designated crimes.

If at any time during your employment as a Support Broker you are charged with any criminal activity which might impact your ability to work with vulnerable adults, according to IDAPA rules (16.03.13), you are required to report this charge immediately to your employer. A substantiated charge of abuse, neglect, exploitation, or a criminal conviction of any crime which would disallow you to work with Department participants must be reported to your employer immediately.

Training

Q: What kind of training do I need to be a Support Broker?
A: A Support Broker must pass an exam prior to providing any paid services to the participant. Taking the training courses provided by the Department will help you pass the exam.

There are many training tools and courses available to individuals that want to be a Support Broker. The Department maintains an external web site regarding the Self-Directed Community Supports program at: **www.selfdirection.idaho.gov**. The *Support Broker Training Curriculum* is available on this web site. You may need additional software to support the program. Directions for additional software are available on the web site at:
http://healthandwelfare.idaho.gov/portals/rainbow/training/sbt2005/index.html.
The Support Broker qualification exam is based on this curriculum. The training is self-paced and will require approximately forty (40) hours of reading, viewing, and studying the material to complete the exam.

Another useful tool may be, *How to Be a Support Broker: An Instructions and Procedures Manual.* This manual covers procedures, policies, and specific information on doing the job of a Support Broker. It has helpful information on subjects ranging from negotiating an employment agreement, to helping your employer, to supervising community support workers. It contains important information regarding when and how to report suspected abuse, help in a crisis, and resign from employment.

Medicaid sponsored training is available monthly through each local Regional Medicaid Services Center. Contact your local regional staff for specific information on dates, times, and course availability. For local regional staff names and phone numbers, see Appendix B.

The Support Broker Qualification Examination

The Exam Process

The Support Broker qualification examination is given monthly at your Regional Medicaid Services Center. Call to arrange a date and time to take the exam at the center in your area. The following apply when taking the Support Broker written exam:

- The Support Broker exam is pass/fail.
- You must receive a score of seventy (70) percent or better to pass the exam.
- You may take the exam up to three (3) times in a twelve (12) month period.
- If you fail the exam three (3) times, you must wait twelve (12) months from the last failed exam date to re-take it.
- The exam consists of multiple choice questions based on information contained in the on-line Support Broker curriculum.
- This is a closed-book exam.
- The applicant will not be allowed to bring books or other written material, cell phones, back packs, purse, or hand held electronic devices into the exam room.
- Walk-ins will not be accepted.
- The test will be offered at least once monthly during a regular business day, during regular business hours.
- Please allow for ninety (90) minutes to take the exam.
- The exam will be administered at the Regional Medicaid Services Center.
- Each applicant will take the test in a private room.
- Upon arrival at the Regional Medicaid Services Center, the Support Broker candidate must check in with the office receptionist.
- The receptionist will notify the Quality Assurance/Quality Improvement Trainer.
- The Quality Assurance/Quality Improvement Trainer will meet with the Support Broker candidate and brief them on the process.
- The applicant must present photo identification at the time of the exam.
- At the scheduled time, the Quality Assurance/Quality Improvement Trainer will have a copy of the Support Broker exam ready for the Support Broker candidate and, if needed, provide the applicant with writing instruments, to complete the exam. The exam should be completed in ink.
- The Quality Assurance/Quality Improvement Trainer should remain available to the candidate in the event assistance is needed during the exam, but does not need to remain in the same room.
- When the exam is completed the Quality Assurance/Quality Improvement Trainer will place the exam in a manila envelope, seal it, and mail it to:

  Division of Medicaid, Bureau of Developmental Disabilities Services
  Attn: Support Broker Exam Scoring
  3232 Elder Street
  Boise, ID 83705.
- The sealed exam will be received by the Bureau of Developmental Disability Services and will be scored using the Support Broker exam master key.

Q: How much does it cost to take the Support Broker exam?
A: There is no fee for the exam.

Passing the Exam

If you score seventy (70) percent or higher on the qualification exam, you will be sent a notice verifying you have completed the application process to become a Support Broker. This notice will be mailed within thirty (30) days from the date of the exam. Additionally, your name will be placed on a register of approved Support Brokers. This register is maintained by the Department of Health and Welfare on the external Self-Directed Community Supports web site found at: **www.selfdirection.idaho.gov**. You will need to re-certify prior to the expiration date of your qualification date to remain certified and on the register.

Failure to Pass the Exam

If you score sixty-nine (69) percent or lower on the qualification exam, you will be sent a notice stating that you have not passed the exam. This notice will be mailed within thirty (30) days from the date of the exam.

Receiving Your Notice of Qualification

Here is a checklist of things you need to do to become a qualified Support Broker.

- Submit your complete application.
- Pass your criminal history check.
- Pass the qualification examination.
- Obtain the letter with notification that you are a qualified Support Broker.

The letter will serve as your qualification and must be presented to both your employer and the Fiscal Employer Agent when you complete your employment packet.

Annual Re-Qualification

The anniversary date for the annual re-qualification is one (1) year from the date on your original Notice of Support Broker Qualification. In order to be re-qualified as a Support Broker, you must submit the following:

1. An application for re-qualification, which can be found in *Appendix A*.
2. Documentation that you have completed a minimum of twelve (12) hours of training in subjects specific to Support Broker job duties and responsibilities.
    - Documentation can be provided by:
        - Certificates of completion.
        - Continuing education units.
        - Community education verification of course completion.
        - Report cards from an educational institution.
    - Training may be taken through:
        - Your Regional Medicaid Services Center.

  - Private trainers.
  - Agencies contracted with the Department of Health and Welfare.
  - Local community education classes.
  - College courses.
  - Workshops.
  - Seminars.
  - Conventions.
  - On-line training.
  - Self study.
- Training subjects can include but are not limited to:
  - Person centered planning and related topics.
  - Plan development.
  - Budget development and budget monitoring.
  - Staff supervision.
  - Employment negotiation.
  - Conflict resolution.
  - Maintaining a circle of support.
  - Community resource identification/integration.
  - IDAPA rules and/or Medicaid policies.
- A maximum of six (6) hours a year of the required twelve (12) hours of training can be completed through self-study.
- Self-study can take the form of reading and/or on-line courses; verification can be obtained through:
  - A brief synopsis of the self-study course, including a written description of the material, where it can be located, and specifics of how it applies to Support Broker job duties.

If you do not provide documentation of twelve (12) hours of annual training, your Support Broker qualification will expire on its anniversary date.

Q: How soon do I need to submit my application for re-qualification?
A: Forty-five (45) days prior to the expiration date of your current Support Broker Qualification Notice.

Approval of Application

If your application is approved, you will be sent a letter notifying you prior to the expiration of your current one (1) year qualifying notice. Your original date of qualification will continue to be your annual renewal date.

Denial of Application

If your application does not demonstrate that you have completed twelve (12) hours of on-going training, you will receive a notice that you must submit further documentation or additional training before you can continue paid work as a Support Broker. This letter will contain specific information to your case. Your current qualification will lapse on the annual renewal date and you will not bill or get paid for Support Broker services until you receive a notice of continuing qualification.

You will not be able to continue to work as a qualified Support Broker if you have been convicted of a criminal charge which disqualifies you from providing Medicaid services or if there is a substantiated report that you have been found to be the perpetrator in a case of abuse or neglect against a child or vulnerable adult.

Quality Assurance

The Support Broker functions are integral to the success of individuals in Self-Directed Community Supports. As a Support Broker, you must be experienced in working with individuals with developmental disabilities. You must also be knowledgeable and qualified to fulfill this role with the participant. You must perform the functions required by IDAPA rules and must be able to perform additional functions as needed by your employer. Support and Spending Plans are reviewed by the Department of Health and Welfare to assure that participant needs are met and significant risks are addressed. A monitoring review/survey of Support Brokers and their participant files are completed to assure compliance with rules. Participant Experience Survey software is used to collect information from participants and monitor participant satisfaction. Support Brokers with variances identified in: the Participant Experience survey, review of complaints, and/or Support and Spending Plan reviews, may be selected for an additional quality assurance review.

Terminating a Support Broker Employment Agreement

The Department of Health and Welfare, Division of Medicaid, may terminate a Support Broker employment agreement at any time. In most cases, remediation will be attempted by the regional Quality Assurance/Quality Improvement Trainer prior to revocation. Termination may occur in the event that a Support Broker fails to perform their job duties adequately despite a plan of correction.

CHAPTER TWO: STARTING THE JOB

Notifying a Potential Employer/Finding an Employer

The Central Office Bureau of Developmental Disability Services has a master list of qualified Support Brokers publicized on the Self-Direction web site at: **http://www.healthandwelfare.idaho.gov/site/3618/default.aspx**. This list is available for anyone in the public sector to access. You will be asked on your Notice of Qualification whether you want your name, phone number, and email publicized on this list.

Your Employer

Medicaid rules state that your employer is a person who is eligible for Home and Community Based Developmental Disabilities Waiver services. They can choose consumer directed services as an option. Consumer directed services allow participants to have greater freedom to manage their own care. They must hire a Support Broker to act as an ongoing link with personal network members, community support workers, vendors, professionals, the funding body, and the wider community.

Submitting the Enrollment Packet

Once you have been hired, you and your employer will complete an employment agreement. Prior to being able to bill for services, you need to enroll with the Fiscal Employer Agent. You cannot be paid for any services until your enrollment packet is complete and accepted, and you have a signed employment agreement that is supported by the authorized Support and Spending Plan.

The Fiscal Employer Agent enrollment packet will be given to your employer when they attend the Guide to Self-Directed Life training. They can also get it directly from the Fiscal Employer Agent by mail or at a Fiscal Employer Agent training seminar. All information is to be filled out and submitted to the Fiscal Employer Agent. Your employer will receive training from the Fiscal Employer Agent on how to complete their forms for enrollment, and how to complete the forms for their employees.

Make sure your employer has enrolled with the Fiscal Employer Agent before you complete your employment agreement and Fiscal Employer Agent enrollment for yourself. Your employer may need your assistance, so this step-by-step will help you, help them.

Fiscal Employer Agent Enrollment Process for the Employer

- The participant gets the Fiscal Employer Agent enrollment packets.
  - The participant completes their training with the Fiscal Employer Agent on how to fill out and submit the packet by phone, mail, fax, or through a training seminar.
- The participant completes the Fiscal Employer Agent enrollment packet.
- The participant mails the enrollment packet back to the Fiscal Employer Agent.
- The Fiscal Employer Agent will review the packet.
  - If there are errors, or the packet is incomplete, the Fiscal Employer Agent will return the forms for correction and resubmission.

- The Fiscal Employer Agent notifies the participant and Medicaid of successful enrollment.
- The Fiscal Employer Agent mails the participant their employer identification number. This number is used on all time sheets for the community support workers hired by the employer, including the Support Broker.

Fiscal Employer Agent Contact Information:
Amber Jones, FPC
Acumen Fiscal Agent, LLC
4542 E. Inverness Ave., Suite 210
Mesa, Arizona 85206
(877) 853-3717
(800) 854-4037(fax)
amberj@acumen2.net

Fiscal Employer Agent Enrollment Process for Employees

Once your employer has successfully enrolled with the Fiscal Employer Agent, and has received their employer identification number, you and other community support workers can enroll. If they wish, the employer can simultaneously submit their own enrollment packet with the packets of their employees.

- The Support Broker and other community support workers receive their enrollment and related forms directly from their employer.
- The Support Broker or other employee completes the forms as needed.
- These forms include state and federal tax withholding information and information regarding time sheets and payment.
- The employee submits the completed forms to the Fiscal Employer Agent.
- The Fiscal Employer Agent reviews all of the forms.
  If there are errors, or the forms are incomplete, the Fiscal Employer Agent will return the forms for correction and resubmission.
- The Fiscal Employer Agent will notify the employee of successful enrollment by mailing the employee an identification number.
- This number is subsequently used on all time sheets.

Your Employment Agreement

You cannot bill and will not be paid for Support Broker services until:

- You have passed the exam.
- You have valid, signed employment agreements and other necessary documents filed with the Fiscal Employer Agent.
- You have received your employee identification number from the Fiscal Employer Agent.

You will sign two (2) employment agreements:

- The Medicaid Support Broker Agreement.
- The Participant Support Broker Agreement.

You must use the employment agreement templates authorized by the Department of Health and Welfare. Templates for both agreements can be found in *Appendix C.* The Medicaid Support Broker Agreement will be part of the employment packet you receive

from the Fiscal Employer Agent once you have been hired by a participant. The Participant Support Broker Agreement is filled out with your employer at the time you agree upon your job duties.

The Participant Support Broker Employment Agreement is renewed annually, at the time the participant is approved for another year of Developmental Disabilities Waiver services and receives their individualized budget. Therefore, each employment agreement is for no more than twelve (12) months.

Items that must be in the Participant Support Broker Agreement include:

- How often you will do each task and the approximate time each task will take.
- How often you will meet with your employer and their circle of support.
- Required and requested employment duties, as defined by Idaho Administrative Procedures Act (IDAPA) 16.03.13, and listed in chapter one.

Suggestions for drafting an employment agreement:

- Identify and list what services you will be accomplishing and coordinating for your employer.
- Specify how often you will meet with your employer, how often you will have phone contact with your employer, and how many hours a month you expect to spend in direct contact with your employer.
- List the required job duties first and then how much time these duties are expected to take.
- List the discretionary tasks that you and your employer agree upon separately from the required job duties.
- Prioritize the list of discretionary job duties.
- Approximate how many hours a week or month you will need to complete the discretionary tasks.
- Determine if the amount of total time a week/month for required and discretionary tasks fall within your employer's expectation of what support brokerage will cost; if it doesn't, make adjustments with your employer using the wiggle room provided in the discretionary list.
- List the negotiated wage (maximum wage amount is $18.72 per hour).
- You cannot provide any other paid services to your employer, outside of the Support Broker duties listed on the employment agreement.
- The budget for Support Broker duties should not jeopardize the budget needed for other support services.

A sample Support Broker task list can be found in *Appendix C.*

Agreement Approval

This agreement must be approved and signed by your employer and their guardian if they have one.

Q: What if more than one participant wants to use my services?
A: It is within the scope of this position to have more than one employer. As long as you fulfill the requirements with each employer and maintain the privacy of each participant, feel free to work for more than one employer.

Financial Management Services

Your employer must purchase Financial Management Services to participate in the Self-Directed Community Supports option. The Department will contract with a Fiscal Employer Agent to provide Financial Management Services to participants who choose the Self-Directed Waiver option. The Fiscal Employer Agent provides financial guidance and support to the participant by tracking individual expenditures, monitoring overall budgets, performing payroll services, and handling billing and employment related documentation responsibilities. According to IDAPA 16.03.13, the Fiscal Employer Agent must meet the following requirements and provide the following services:
The Fiscal Employer Agent performs Financial Management Services for each participant. Prior to providing Financial Management Services, the participant and the Fiscal Employer Agent must enter into a written agreement.
Financial Management Services include:

1. Payroll and Accounting. Providing payroll and accounting supports to participants that have chosen the Self-Directed Community Supports option.
2. Financial Reporting. Performing financial reporting for employees of each participant.
3. Information Packet. Preparing and distributing a packet of information, including Department - approved forms for agreements, for the participant hiring his own staff.
4. Time Sheets and Invoices. Processing and paying time sheets for community support workers and support brokers, as authorized by the participant, according to the participant's Department-authorized Support and Spending Plan.
5. Taxes. Managing and processing payment of required state and federal employment taxes for the participant's community support workers and support brokers.
6. Payments for Goods and Services. Processing and paying invoices for goods and services, as authorized by the participant, according to the participant's Support and Spending Plan.
7. Spending Information. Providing each participant with reporting information that will assist the participant with managing the individualized budget.
8. Quality Assurance and Improvement. Participating in Department quality assurance activities.

Getting Paid through the Fiscal Employer Agent

The Fiscal Employer Agent issues paychecks on behalf of your employer. If you have questions, need help filling out the forms, or have concerns regarding your paycheck, contact the Fiscal Employer Agent directly, by calling their customer service line. Their customer service is available during regular business hours, Monday – Friday, with the exception of holidays. In order to be paid, you must have completed the following steps:

- Ensure that the Support Broker services you perform are accurately budgeted on the Employment Agreement and your employer's Support and Spending Plan.
- Be enrolled with the Fiscal Employer Agent (Acumen).
- Have receipt of an employee ID number from the Fiscal Employer Agent.
- Have your employer review and sign your time sheet.
- Submit a complete and signed time sheet to Acumen.

You are paid every two (2) weeks, according to the time schedule provided to you by the Fiscal Employer Agent (Acumen). You must have your time sheet signed and submitted by the specified dates to ensure payment at the next payroll day. You are only paid for the actual hours you work.

A copy of a time sheet is included in *Appendix H*. You will need to list each service date in full, and the time you begin and end work. The last column is titled "Service." You only provide one service, that of a Support Broker. You will always code your time as SBS. You need to fax or mail your time sheet to Acumen by the appropriate due date. The address and fax number are on the bottom of the time sheet.

The Good News

"When do I get my first pay check" is a natural question most people ask when they start a new job. Your first pay check will encompass all the hours you have put into developing the Support and Spending Plan thus far. Your Employment Agreement details the hours including:

- Meeting with your employer and their Circle of Supports.
- Helping your employer fill out their *My Voice My Choice Workbook*.
- Researching and calculating rates for services and prices of goods that need to be purchased.

You will need to complete time sheets even though you cannot submit them until the Support and Spending Plan is authorized. The Fiscal Employer Agent will process time sheets in bulk once they have received an authorization for the plan.

The Not-So-Good News

You cannot get paid until the Support and Spending Plan is authorized. You will be doing work up-front for payment at a later date. If your employer has a current Individual Service Plan and is receiving services through the traditional waiver option, they still have a Plan Developer/Service Coordinator. That person will continue to provide and bill for services. You need to be able and willing to work with them during those crucial transition months. They can help you and your employer by providing valuable information and maintaining contact with current services and Medicaid. They will be expected to continue with their normal job duties until the current Individual Service Plan expires. This means they are responsible for handling service needs and any problems

that arise during this time. Your first paycheck will reflect the hours authorized for you to meet with the Circle of Support and develop the Support and Spending Plan.

CHAPTER THREE: THE SUPPORT AND SPENDING PLAN

Steps to Develop a Support and Spending Plan

The Support and Spending Plan is the key to your employer's ability to manage their services and realize their dreams. The intent of the total Support and Spending Plan is to ensure that your employer gets the supports they need to become as independent as possible.

Identifying the Circle of Support

The first step in building a Support and Spending Plan is to identify the Circle of Support. These will be the people you meet with to develop the Support and Spending Plan. According to Idaho Administrative Procedures Act (IDAPA) 16.03.13, the circle of support is composed of people who care about the participant and provide unpaid support.

1. Focus of the Circle of Support. The participant's circle of support should be built and operate with the primary goal of working in the interest of the participant. The group's role is to give and get support for the participant and to develop a plan of action, along with and on behalf of the participant, to help the participant accomplish his personal goals.
2. Members of the Circle of Support. A circle of support may include family members, friends, neighbors, co-workers, and other community members. When the participant's legal guardian is selected as a community support worker, the circle of support must include at least one (1) non-family member that is not the support broker.
3. Selection and Duties of the Circle of Support. Members of the circle of support are selected by the participant and commit to work within the group to: a. Help promote and improve the life of the participant in accordance with the participant's choices and preferences; and b. Meet on a regular basis to assist the participant to accomplish his expressed goals.
4. Natural Supports. A natural support may perform any duty of the support broker as long as the support broker still completes the required responsibilities. Additionally, any community support worker task may be performed by a qualified natural support person. Supports provided by a natural support person must be identified on the participant's support plan, but time worked does not need to be recorded or reported to the fiscal employer agent.

Additional information on the Circle of Support can be found through the following sources:

- Review Module 'C' of the Support Broker Training Curriculum at: **www.selfdirection.idaho.gov**.
- Regional Training: The contacts, addresses, and phone numbers for the Regional Medicaid Services Center are listed in *Appendix B.* Contact them for more information on local training opportunities.

Use the Guide to a Self-Directed Life

The *Guide to a Self-Directed Life* is the consumer handbook that has been developed for individuals in the Self-Directed Option Waiver. It can be found on the Self-Direction web site listed above. The guide gives specific directions and instructions for participants and suggests that they use their Support Brokers to help identify members of their Circle of Support.

It is important that individuals use natural (unpaid) supports as much as possible. Each participant has a limited budget. The Support Broker fee must comprise only one small part of that budget.

The Circle of Supports is essential in developing and maintaining the independence of the participant.

Use the Person Centered Planning Process and The My Voice My Choice Workbook

The *My Voice My Choice Workbook* helps the individual to identify how they want to spend their support and service budget. The employer may ask for help when filling out the handbook. Each individual will be given a copy of the *My Voice My Choice Workbook* when they choose the Self-Directed Option.

- The *My Voice My Choice Workbook* must be returned to the Regional Care Manager with the completed Support and Spending Plan.
- Make sure you or your employer make a copy of the workbook and the Support and Spending Plan before turning them into the Regional Care Manager.

The term Person Centered Planning is used to describe the concept of consumer-driven support planning. Person Centered Planning helps the Circle of Support identify how to meet the needs and goals of the participant. The Workbook and Person Centered Planning form the foundation for the Support and Spending Plan.

You need to be mindful of how much time you can spend with your employer helping with the workbook. You should try to identify how many hours it will take to complete the Person Centered Planning meetings and help with the Support and Spending Plan. These duties and hours must be included in the employment agreement.

Your employer may need the help of other professionals to complete portions of the workbook. The workbook includes information on health and safety risks and needs. Health professionals may need to be consulted. As you review the workbook, please note how much time may be needed in gathering health and safety information from others. Make sure you include this time in your employment agreement.

Use the Individualized Budget

The individualized budget is the amount of money that each individual can spend annually to purchase their Medicaid allowable supports and services. The individualized budget is set through a specific process, based on each person's assessed and identified

needs. Each individual is advised of their budget in their waiver eligibility approval letter.

You must know the annual budget amount for each of your employer's supports and services prior to submitting a Support and Spending Plan. The Plan must fit within the parameters of the individualized budget or it will be rejected.

Your employer must purchase Financial Management Services and Support Broker Services to participate in the Self-Directed Community Supports option. They will use their budget to purchase goods and community supports. In addition, they may need to pay employer taxes and Worker's Compensation Insurance. The Fiscal Employer Agent can help you calculate the employer tax and Worker Compensation Insurance costs.

Individuals cannot exceed their annual budget. If your employer cannot budget their expenses to fit within their individualized budget, you will need to help them review their options.

Calculate Allowable Expenses

The individualized budget is used to purchase your employer's needed supports and services. The budget will pay for the Fiscal Employer Agent, Support Broker services, Community Support Worker services, necessary equipment, and supplies. The Community Support Worker provides identified supports to the participant. If the identified support requires specific licensing or certification within the State of Idaho, the Community Support Worker must obtain the applicable licensing or certification requirements.

Help your employer figure out the costs of each service they want to use. Make sure each service is allowable, according to IDAPA 16.03.13. See *Appendix A* for the list of allowable expenses. The Support and Spending Plan provides worksheets to help you.

Identified supports include activities that address the participant's preferences for:

a. Job support to help the participant secure and maintain employment or attain job advancement;
b. Personal support to help the participant maintain health, safety, and basic quality of life;
c. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community;
d. Emotional support to help the participant learn and practice behaviors consistent with his goals and wishes while minimizing interfering behaviors;
e. Learning support to help the participant learn new skills or improve existing skills that relate to his identified goals;
f. Transportation support to help the participant accomplish his identified goals;
g. Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes his increased independence; and
h. Skilled nursing support identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed professional (RN) nurse or

licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

As a Support Broker, you are responsible for knowing which expenses are, and which are not allowed by Idaho Department of Health and Welfare, Medicaid Division, and the Self-Directed Community Supports Program. *Appendix A* lists both categories.

Review Rates and Budgeting

Medicaid has negotiated rates for specific supports and services for individuals using traditional Medicaid providers. A current rate chart is included in *Appendix B.* You can use these figures to help estimate costs of services for the individual when planning a budget.

In addition, you can help your employer negotiate wages and rates. The Self-Directed individual is not bound by previously negotiated Medicaid rates. They can offer what they consider to be fair-market payment for the supports and services they require. As long as those services are allowable under the Medicaid rules and guidelines, the cost is negotiable.

The Support and Spending Plan includes specific worksheets for budgeting. These worksheets should be used to help your employer calculate the cost of each paid service/support.

Instructions on how to use the budgeting sheets are included in the plan. You can help your employer by encouraging community resource exploration.

Employer Taxes

When your employer hires a Community Support Worker to provide hourly services, an additional ten (10) percent cost needs to be added to the budget, for each hour of work being paid to the service provider. This additional cost goes on the My Spending Plan Worksheet. This additional ten (10) percent is the individual's employer share of Social Security, Medicare, and Federal and State unemployment taxes. The employer is responsible for paying these taxes as an employer under the Self-Directed Community Supports option.

The Fiscal Employer Agent includes a chart in their enrollment packet which helps calculate employer taxes based on an hourly rate of pay. Your employer can use this chart when filling out their Support and Spending Plan budget amounts.

Calculating Sales Tax

Your employer will need to pay sales tax on items (goods) they purchase from a vendor. The only exception to this is in the case of items which are prescribed by a professional health practitioner. (See the section below for more information.) The current sales tax in Idaho is six (6) percent, or .06 cents for each dollar spent. Your employer may need to purchase specific goods to help them remain as independent as possible in the community. For example, your employer may need to purchase a microwave because they are unable to use a stove. They can use a microwave to safely cook hot meals for themselves. This would be an allowable expense because it will help them remain in the least restrictive and most normal setting.

For example: Your employer needs to include the price of the microwave on their Support and Spending Plan. In addition, they must calculate the sales tax and include that in the total cost. So, if the microwave costs $50.00, your employer must put the total amount needed, including sales tax, on their plan: The total cost would be $53.00.

Tax Exempt Items

Items prescribed by a physician, surgeon, podiatrist, chiropractor, dentist, optometrist, psychologist, ophthalmologist, nurse practitioner, denturist, orthodontist, audiologist, or hearing aid dealer or fitter may be tax exempt.

These items include:

- Prescription drugs.
- Braces and other orthopedic appliances.
- Catheters and similar supplies.
- Diabetic monitoring and testing supplies and equipment.
- Prosthetic devices.
- Other durable medical equipment.

If your employer routinely uses the above items, please check to see that they have a prescription from their physician. They can then buy these items without paying sales tax. If you are not sure if an item falls under this category, check with your employer's physician or with your local vendor. They should be able to tell you.

Developing the Support and Spending Plan: What Must Be Included?

According to IDAPA 16.03.13, the participant, with the help of his Support Broker, must develop a comprehensive Support and Spending Plan based on the information gathered during the person-centered planning meeting. The Support and Spending Plan is not valid until authorized by the Department and must include the following:

a. The participant's preferences and interests by identifying all the supports and services, both paid and non-paid, the participant wants and needs to live successfully in his community;

b. Paid or non-paid self-directed community supports that focus on the participant's wants, needs, and goals in the following areas:
    i. Personal health and safety including quality of life preferences;
    ii. Securing and maintaining employment;
    iii. Establishing and maintaining relationships with family, friends, and others to build the participant's circle of supports;
    iv. Learning and practicing ways to recognize and minimize interfering behaviors; and
    v. Learning new skills or improving existing ones to accomplish set goals.
c. Support needs such as:
    i. Medical care and medicine;
    ii. Skilled care including therapies or nursing needs,
    iii. Community involvement;
    iv. Preferred living arrangements including possible roommate(s); and
    v. Responses to emergencies including access to emergency assistance and care. This plan should reflect the wants, preferences, and needs of the whole person, regardless of payment source, if any.
d. Risks or safety concerns in relation to the identified support needs on the participant's plan. The plan must specify the supports or services needed to address the risks for each issue listed, with at least three (3) backup plans for each identified risk to implement in case the need arises;
e. Sources of payment for the listed supports and services, including the frequency, duration and main task of the listed supports and services; and
f. The budgeted amounts planned in relation to the participant's needed supports. Community support worker employment agreements submitted to the fiscal employer agent must identify the negotiated rates agreed upon with each community support worker along with the specific support being purchased, the frequency and duration that the support will be provided, and the payment increment. The Fiscal Employer Agent will compare and match the employment agreements to the appropriate support categories identified on the initial spending plan prior to processing time sheets or invoices for payment.

Identifying Related Risks

As you help your employer fill out the *My Voice My Choice Workbook*, you will notice that there are many prompts to help identify risks. The prompts include questions about health and safety. These questions help you identify possible risks. Some of the prompts having to do with health and safety include:

- "Who knows about your health and safety needs?"
- "Are there any relationships you are uncomfortable with?"
- " What help do you need at home to make sure things get done that are important to you and your well being?"

If your employer must have a specific support or service in order to maintain their health, safety, or quality of life, then the lack of that support or service constitutes a risk.

For example: If your employer needs a Community Support Worker to supervise them to take their medication and prepare a meal every morning, they may be at risk if the Community Support Worker unexpectedly does not come to work.

You need to identify this risk on the My Health and Safety Plan Worksheet and you will need to identify three (3) realistic backup plans for this risk.

For example: If a Community Support Worker does not show up to work, in the plan it may be written that:

- The participant has the ability to phone their guardian and the guardian agrees to handle the problem.
- The participant has a back-up Community Support Worker who is available for emergency service and the participant has the ability to phone this Community Support Worker.
- The participant has the ability to get a next-door neighbor who has agreed to act as back-up in an emergency situation.

The Risk Identification Tool

There is a checklist available in *Appendix E* to help you and your employer identify risks. Any risks identified should have a corresponding Support and Spending Plan that addresses the risk. However, depending on the nature of the support provided to lower the risk, there may not be an issue of "immediate jeopardy". It is only when there is an "immediate jeopardy" to the participant's health and safety that a back-up plan has to be developed. In those instances, three (3) back-up plans need to be created and made available.

Many people with developmental disabilities are at high risk for the following health-threatening conditions:

- Seizures.
- Dehydration.
- Constipation.
- Choking.

If your employer has a history of these conditions, be sure to consult with their physician and include safety plans in their Support and Spending Plan.

Support and Spending Plan Limitations

According to IDAPA 16.03.13.160, the Support and Spending Plan limitations include:

a. Traditional Medicaid waiver and traditional rehabilitative or habilitative services must not be purchased under the self-directed community supports option. Because a participant cannot receive these traditional services and self-directed services at the same time, the participant, the support broker, and the Department must also work together to assure that there is no interruption of required services when moving between traditional services and the SDCS option.
b. Paid community supports must not be provided in a group setting with recipients of traditional Medicaid waiver, rehabilitative or habilitative services. This limitation does not preclude a participant who has selected the self-directed option from choosing to live with recipients of traditional Medicaid services.
c. All paid community supports must fit into one (1) or more types of community supports described … (in statues). Community supports that are not medically necessary or that do not minimize the participant's need for institutionalization must

only be listed as non-paid supports. Additionally, the Support and Spending Plan must not include supports or services that are illegal, that adversely affect the health and safety of the participant, that do harm, that violate or infringe on the rights of others.

d. Support and Spending Plans that exceed the approved budget amount will not be authorized.
e. Time sheets or invoices that are submitted to the fiscal employer agent for payment that exceed the authorized Support and Spending Plan amount will not be paid by the fiscal employer agent.

Writing the Plan

The following list may help you when you begin writing the plan:

- Identify who is in the Circle of Support.
- Circle of Support should be involved with developing and creating the plan.
- Review the *Guide to a Self-Directed Life.*
- Review the *My Voice My Choice Workbook.*
- Ensure the *My Voice My Choice Workbook* is filled out.
- Know the amount for the annual individualized budget.
- Know what services and supports (allowable expenses) can be purchased with Medicaid funds.
- Review the usual rates for services and know what amounts are within Medicaid's parameters.
- Explore and identify natural supports, community resources, and low-cost alternatives.
- Know what must be included in the Support and Spending Plan.
- Identify the risks and backup plans.
- Make a list of your employer's specific goals and needs, as identified in their *My Voice My Choice Workbook.*
- Have your employer and their Circle of Support identify how to access community resources.
- Identify what times and days your employer may want/need supports and services.
- Ask questions about how often they might need extra help.
- Find out if your employer needs any paid support during vacations.
- Identify what your employer can do for themselves.
- Ask your employer if they are in agreement with the information in the *My Voice My Choice Workbook.* If they do not agree, keep working with them and their Circle of Support until they do agree with what has been created.

Once you have completed all the steps and located the above information, use the *My Voice My Choice Workbook* to transfer information to the Support and Spending Plan. The plan has instructions for completing each step. Once the budget pages are complete, submit the *My Voice My Choice Workbook* and Support and Spending Plan to the Regional Care Manager.

Tips for filling out the Support and Spending Plan:

- Read all the instructions; make sure all pages are complete and correct.

- Type the plan.
- If a particular category of service will not be used, draw a line through that section so the Regional Care Manager knows that it has been omitted.
- Your employer and their Circle of Support decide what service goes under what category. Each service is broadly defined.
- The Fiscal Employer Agent expenditure must be included in the budget. The Fiscal Employer Agent costs the participant $78.00 a month for a total of $936.00 a year. This annual amount is written on the Plan Authorization sheet in the top left-hand corner.
- The total costs of the Support Broker (you) and all Community Support Workers must be included. These annual amounts are recorded on the plan authorization sheet in the top left-hand corner.
- Include employer taxes and sales taxes as needed for each category, and in the total annual amounts.

In the Mean Time: Your Employer's Service Needs

Your employer will submit their Support and Spending Plan to the Regional Care Manager for authorization. While they are going through this process, they still need to have the usual services. If this is the first time your employer is accessing the Self-Directed option, they probably have an Individualized Service Plan which is still active.

The current plan developer/service coordinator needs to be actively involved in ensuring that your employer's services continue. If your employer needs to request an extension, the service coordinator is the person to make sure this gets done.

TIP: Self-Direction does not have the ability to extend services like the traditional pathway. The participant will receive notice from Idaho Center for Disabilities Evaluation regarding eligibility re-determination one hundred and twenty (120) days prior to the end of the plan year. You and your employer will have ninety (90) days to complete a new Support and Spending Plan. It is important that you complete a new Plan and submit it for review at least ten (10) days prior to the end of the current plan year because this is how long the Regional Care Managers have to review the plan. There is also the possibility that all the services may not be approved, so submitting it earlier can help in this situation.

Navigating the Future!
Knowing who to contact for updated information is important. The Idaho Council on Developmental Disabilities has a lot of information on current events and upcoming changes.
Contact them at:
802 W. Bannock, Suite 308 Boise, Idaho 83702
(208) 334-2178
Email: **icdd@icdd.idaho.gov**
Web: **www.icdd.idaho.gov**

CHAPTER FOUR: GETTING THE PLAN AUTHORIZED

Everyone needs a plan, and most of us have one. We don't always write it down but we know what it is. People who have disabilities also have plans. In the Self-Directed option, their plans have to be written down, carefully budgeted, and approved by a Regional Medicaid Care Manager. Make sure the Support and Spending Plan reflects what your employer wants and that it will help them become who and what they want to be.

Presenting the Plan to the Regional Care Manager

The participant and the Support Broker will submit a Support and Spending Plan to the Regional Medicaid Care Manager for review. The Regional Medicaid Care Manager has ten (10) business days to review the plan. Make sure you or your employer keep a copy of all documents that are submitted to the Regional Medicaid Care Manager.

The Regional Medicaid Care Manager reviews the plan using the following criteria:

- Services and supports must meet the guidelines for allowable expenses.
- Services and supports must not exceed the approved budget amount.
- The *My Voice My Choice Workbook* must be included with the Support and Spending Plan.
- The completed My Health and Safety Plan form must be included in the Workbook. Any risks identified on the form or on the Risk Identification Tool must have a corresponding My Support Plan.
- Each service or support must include the source of payment, frequency, duration, desired goal associated with the listed support or service, and annual cost associated with each support or service.
- A Support Broker must be listed on each Budget Summary Sheet.
- The Fiscal Employer Agency must be listed on the Budget Summary Sheet.
- An Agreement to Self-Direct form must be attached to the Support and Spending Plan.
- Support and Spending Plan and Budget Summary Sheet must be typed.
- Each field on the Support and Spending Plan must be completed, even if only with the designation N/A.
- Informed consent statement on the demographic page must be signed and dated.

If participant is receiving twenty-four (24) hour care in the home of the Community Support Worker (Certified Family Home), the My Support Plan relevant to twenty-four (24) hour care should be all inclusive of the services, tasks and/or goods required of a Certified Family Home in Idaho Administrative Procedures Act (IDAPA 16.03.19 Rules Governing Certified Family Homes). These responsibilities include:

01. Supervision. Appropriate, adequate supervision for twenty-four (24) hours each day unless the resident's plan of service provides for alone time.
02. Daily Activities and Recreation. Daily activities, recreational activities, maintenance of self-help skills, assistance with activities of daily living [i.e. The performance of basic self-care activities in meeting a participant's needs to be sustained in a daily living environment, including bathing, washing, dressing, toileting, grooming, eating, communicating, continence, managing money, mobility and associated tasks] and provisions for trips to social functions, special diets, and arrangements for payments.
03. Medical. Arrangements for medical and dental services and monitoring of medications…
04. Furnishings and Equipment. Linens, towels, wash cloths, a reasonable supply of soap, shampoo, toilet paper, sanitary napkins or tampons, first aid supplies, shaving supplies, laundering of linens, housekeeping service, maintenance, and basic television in common areas…
05. Plan of Service. Development and implementation of the plan of service for private-pay residents and implementation of the plan of service for state-funded residents.
06. Activity Supplies. Activity supplies in reasonable amounts that reflect the interests of the resident.
07. Transportation. Arrangement of transportation in reasonable amounts to community, recreational and religious activities within twenty-five (25) miles of the home. The home must also arrange for emergency transportation.
175. Room, Utilities and Meals. The home must provide room, utilities and three (3) daily meals to the resident. The charge for room, utilities and three (3) meals must be established in the admission agreement.

A copy of the Community Support Worker's current Certified Family Home certificate should be submitted along with the Support and Spending Plan when twenty-four (24) hour care is being provided to the participant in the home of the Community Support Worker.

1. If a service, task, or good identified on a My Support Plan requires licensure or certification of the Community Support Worker or natural support in order to operate in conformity with federal, state, and/or local laws and regulations, the license or certificate must be attached to the Support and Spending Plan (i.e. nurse, psychiatrist, psychologist, speech therapist, physical therapist, occupational therapist).
2. If a doctor's order is required prior to accessing a service or support, a copy of the doctor's order must be attached to the Support and Spending Plan.
3. If a participant's health or safety would be immediately jeopardized if a natural or paid support listed on a My Support Plan didn't provide an identified service, task, or good at the scheduled time, a back-up plan must be developed for this support. The back-up plan should identify three (3) other ways the participant could obtain the

required support. (The Back-up Plan form should be used to create back-up plans for critical supports listed on each of the My Support Plan pages).

4. A Support Broker must be listed on each Support and Spending Plan Authorization.

Take the Next Step:
After reviewing the Support and Spending Plan, the Regional Medicaid Care Manager can either approve the plan, recommend changes needed to approve the plan, or deny the plan. Make sure you and your employer are ready for any outcome.

Approval of the Plan

If the Support and Spending Plan is approved, the Regional Medicaid Care Manager does the following:

- Sends the participant and Support Broker a copy of the Support and Spending Plan approval letter and a copy of the Support and Spending Plan.
- Sends the Fiscal Employer Agent a copy of the Support and Spending Plan Authorization.
- Pre-authorizes the budget associated with the approved Support and Spending Plan.
- Deactivates any outstanding prior authorizations for traditional services, if the participant was currently on the Developmental Disabilities Waiver,

Recommended Changes

If the Support and Spending Plan is not approved as submitted, the Regional Medicaid Care Manager will send a letter to the participant and their Support Broker with the following information:

- Reasons why the Support and Spending Plan was not approved.
- Instructions for re-submitting the plan to the Regional Medicaid Care Manager if modifications are to be made to the plan.
- Instructions to request a Reconsideration of Decision, should the participant decide they do not want to modify and re-submit the plan.

If the re-submitted plan is approved, the Regional Medicaid Care Manager follows the approval process.

When the Plan is Denied

If a Plan is denied, the Regional Medicaid Care Manager sends a letter of denial to the participant and their Support Broker which includes the participant's right to file a Notice of Reconsideration of Denial. The participant has twenty-eight (28) days to file a Request for Reconsideration with the Regional Medicaid Care Manager.

The Reconsideration Request

If a participant files a Request for Reconsideration of Denial with the Regional Medicaid Care Manager, this request is forwarded to Central Office Medicaid, Bureau of Developmental Disability Services. The Bureau of Developmental Disability Services has fifteen (15) days from the date of receipt and any requested documentation necessary to the request to come to a decision. The Bureau of Developmental Disability Services can either approve or deny the plan.

If the Bureau of Developmental Disability Services overturns a regional decision to deny a plan, the Regional Medicaid Care Manager completes the following within three (3) business days of receiving the decision:

- Sends the participant and the Support Broker a copy of the Support and Spending Plan approval letter and a copy of the Support and Spending Plan.
- Sends the Fiscal Employer Agency a copy of the Budget Summary Sheet.
- Pre-authorizes the budget associated with the approved Support and Spending Plan.
- Deactivates any outstanding prior authorization for traditional services.

If the Division of Medicaid upholds a regional decision to deny a plan, the Division of Medicaid sends a Notice of Denial to the participant and their Support Broker. A copy of the Notice is also sent to the Regional Medicaid Care Manager. At this point a participant can elect to receive Developmental Disability Waiver Services through the traditional pathway. Contact information regarding the traditional pathway will be included in the denial letter.

The Fair Hearing Appeal

If the participant does not appeal the denial within twenty-eight (28) days, their Self-Directed Community Supports file will be closed. The participant can elect to use traditional waiver services if this is an initial plan, or remain with their traditional participant service plan if they were transitioning to the Self-Directed option from the traditional waiver services.

If the participant does appeal within twenty-eight (28) days, the Rules Governing Case Proceedings and Declaratory Rulings (IDAPA 16.05.03) will be followed. The appeal rights and how to access the process is included in the Denial Notice that the participant receives when their Support and Spending Plan is denied.

CHAPTER FIVE: THE ROLE OF THE FISCAL EMPLOYER AGENT

What does the Fiscal Employer Agent Do?

The Fiscal Employer Agent:

- Provides enrollment packets to participants in the Self-Directed Option. (The enrollment packet includes employment forms for employees).
- Provides individual training for anyone who needs it for enrollment and employment forms.
- Provides in-person group training for participants and their employees when there are at least five (5) participants present.
- Tracks the criminal history background checks of Community Support Workers and notifies the employer and Medicaid of the results.
- Checks to ensure that employees are not on the Medicaid Exclusion List.
- Provides payment for all services and goods that the employer receives through the Self-Directed Option including:
  - Taxes to state and federal taxing bodies on behalf of the employer.
  - Provides monthly expenditure reports to the employer and the Regional Medicaid Care Manager.
  - Handles complaints and issues related to payroll and purchase problems.
  - Provides other reports that the Department needs to monitor the quality of the service.

The enrollment packets include forms that allow the Fiscal Employer Agent to act as a payroll agent for the individual and to pay their employees. The packet includes all the specific tax forms for the employees, Employment Agreements, and Waiver forms. Participants can get a packet from their Regional Medicaid Care Manager or Fiscal Employer Agent by phone or by attending training. The regional trainer for Self-Direction contacts the Fiscal Employer Agent representative to set-up group trainings. If you are interested, contact the Regional Medicaid Care Manager for information regarding any scheduled group training.

What Does the Fiscal Employer Agent Need to do their Job?

The Fiscal Employer Agent needs the following in order to process payroll and requests for vendor payments:

- Support and Spending Plan Authorization sheet from the Regional Medicaid Care Manager after it is approved.

- Notification from Medicaid that prior authorization for specific service codes have been entered into the Medicaid payment system.
- Complete and correct Employment Agreements for each employee.
  - Current certification or licensure for each employee as required.
  - Current Criminal History Background Check clearance for each employee as required, or Waiver of Criminal History Check.
- Complete and correct Medicaid Employee Agreements for each employee.
- Complete and correct tax forms, including the W-4 and the I9.
- An accurate and signed time sheet for each employee.
- A voided receipt and Request for Vendor Payment for each purchase of goods (see next section).
- An agreement between the insurance company and the employer regarding Worker's Compensation Insurance, if requested.

If an employee submits a time sheet and does not have proper authorization for billing, or the time sheet exceeds the amount authorized, the Fiscal Employer Agent will not pay the employee. The Fiscal Employer Agent will contact the employer and notify them of the situation.

How Does the Fiscal Employer Agent Pay for Purchased Goods?

When your employer needs to purchase an item that is authorized by their plan and covered under their individualized budget, the Fiscal Employer Agent pays the bill for the item. Your employer must take the following steps to ensure payment for goods and services:

- Go to the local vendor and request a voided receipt for the particular item they want to purchase.
- Fill out the Request for Vendor Payment form (this form is in the enrollment packet).
- Mail the voided receipt with the Request for Vendor Payment form to the Fiscal Employer Agent.
- The Fiscal Employer Agent will send your employer a check for the exact amount that is on the voided receipt. (The check will be made out to the vendor and the stub attachment will state specifically what the check is for.)
- The Fiscal Employer Agent will not reimburse your employer for a purchase they have already made.
- The Fiscal Employer Agent will not send a check for an item that is not specified and authorized on the plan.
- Once your employer receives the check they will take it to the vendor and purchase the item(s).
- Your employer must save the receipt for the item and attach it to the stub attachment which states what the check is for. (The receipt will be checked by Medicaid and it must match the attachment for the specific item that was authorized.)

CHAPTER SIX: THE COMMUNITY SUPPORT WORKERS

What is a Community Support Worker?

Idaho Administrative Procedures Act (IDAPA) Rule 16.03.13, defines a Community Support Worker as: An individual, agency, or vendor selected and paid by the participant to provide community support worker services. Services are defined as:

a. Job support to help the participant secure and maintain employment or attain job advancement;
b. Personal support to help the participant maintain health, safety, and basic quality of life;
c. Relationship support to help the participant establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community;
d. Emotional support to help the participant learn and practice behaviors consistent with his goals and wishes while minimizing interfering behaviors;
e. Learning support to help the participant learn new skills or improve existing skills that relate to his identified goals;
f. Transportation support to help the participant accomplish his identified goals;
g. Adaptive equipment identified in the participant's plan that meets a medical or accessibility need and promotes his increased independence; and
h. Skilled nursing support identified in the participant's plan that is within the scope of the Nurse Practice Act and is provided by a licensed professional (RN) nurse or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

In addition, IDAPA Rule states if the identified support requires specific licensing or certification within the State of Idaho, the identified community support worker must obtain the applicable license or certification. Also, a paid community support worker must not be the spouse of the participant and must not have direct control over the participant’s choices, must avoid any conflict of interest, and cannot receive undue financial benefit from the participant’s choices.

Community Support Worker duties and responsibilities include:

1. Prior to providing goods and services to the participant, the community support worker must complete the packet of information provided by the Fiscal Employer Agent and submit it to the Fiscal Employer Agent. When the community support worker will be providing services this packet must include documentation of:
   a. A complete criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks" or documentation that this requirement has been waived by the participant. This documentation must be provided on a Department-approved form and must include the rationale for waiving the criminal history check and describe how health and safety will be assured in lieu of a completed criminal history check. Individuals listed on a state or federal provider exclusion list must not provide paid supports;
   b. A completed employment agreement with the participant that specifically defines the type of support being purchased, the negotiated rate, and the frequency and duration of the support to be provided.
   c. Current state licensure or certification is needed if identified support requires certification or licensure; and
   d. A statement of qualifications to provide supports identified in the employment agreement.
2. The community support worker must track and document the time required to perform the identified supports and accurately report the time on the time sheet provided by the participant's fiscal employer agent or complete an invoice that reflects the type of support provided, the date the support was provided, and the negotiated rate for the support provided.

Helping Your Employer Find Workers

You may be asked by your employer to help them find a Community Support Worker. This can involve helping the employer learn and implement the skills necessary to recruit, hire, and train a Community Support Worker. These are the steps that should be taken during this process:

- Review Chapter 2 regarding the Support Broker Employment Agreement: Make sure you have defined the scope of the task with your employer and written it into the Employment Agreement, and agree on the amount of hours that the employer will pay to have you help with the recruitment and hiring of the Community Support Worker(s).
- Define the specific tasks the Community Support Broker will need to perform: Tasks may include helping the employer develop a job description, place an ad, contact the local Job Service, interviewing, and/or writing an Employment Agreement.

Define the Scope of the Community Support Worker Job

- Specify exactly what your employer's needs are: What will the Community Support Worker do for the employer.
- Define the skills needed for a Community Support Worker to meet those needs: Do they need training, education, licensing, or certification in special areas.

- Identify any desired education, experience, specific physical abilities, or personality traits necessary for the job (i.e. if the job involves heavy lifting, specify how much and how often).
- Specify whether or not the Community Support Worker will need to have a vehicle.
- Decide whether a criminal history check is warranted for the particular position (refer to waiving the criminal history check).
- Help your employer write a draft of the employment agreement to serve as a guide.
  - Identify the frequency and duration of the service for each day, week, or month.
  - Help your employer decide on a pay range that is within their budget (remember to add in additional employer expenses).

Writing a Job Description

- State the name of the job first (i.e. "driver" or "personal care attendant" or "home and yard light maintenance").
- Identify specific duties, hours, and days of the week the service is needed (i.e. "driver needed to transport person with disabilities Monday – Friday to and from job site; pick up at 9:00 am and 3:00 p.m., two hours a day").
- State the location of the job if this is relevant (i.e. "Employer lives in Garden City and job is also in Garden City").
- Identify any necessary requirements (i.e. "must have driver's license, insurance, reliable vehicle, and telephone. Must be at least twenty-one (21) years of age, and be able to pass a criminal history check").
- State pays (i.e. "$6.00 per hour").
- List contact name and phone number.

Finding Staff

There are many methods that can be used to find a good Community Support Worker for your employer. The important point is to define job specifics and requirements as well as how many hours and what type of support is needed prior to advertising so that the ad will attract the right person, for the right job.

- Your employer might already have someone in mind.
- Your employer might have some ideas about where to find Community Support Worker(s).
- Ask your employer's Circle of Support for ideas, help, and referrals.
- Advertise at the local Job Service.
- Advertise in the local newspaper.
- Advertise on the Internet.

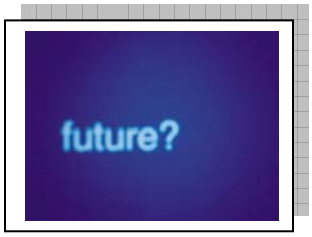
Negotiation of Duties and Wages

Once your employer has located a person who wants to work as a Community Support Worker in a particular position, the next step is to complete the Employment Agreement. There may be some negotiation involved regarding the duties, hours, and wages. Remember to clarify these issues in the ad. Help your employer to fill in a draft of an Employment Agreement. This document can serve as a guide.

Review 'Negotiation' in Module D, Section 3, of the *Support Broker Training Curriculum*. The end result of whatever negotiation takes place will be the Employment Agreement contract. *Appendix B* has an example of rates for services that Medicaid uses. This can give you a starting point when doing negotiations.

Medicaid dollars can only be used for services that are provided. The Self-Direction Waiver does not allow your employer to pay for sick time, vacation, or holidays.

Navigating the Future!
It is a good idea to offer a starting wage below the authorized funding so that the employer can give a merit and/or longevity raise in the future!



Waiving the Criminal History Background Check

Your employer has the option to waive the criminal history background check for a Community Support Worker. This means that your employer can choose to not have a criminal history background checked on a particular worker. However, if your employer chooses this option, they have to submit a written statement explaining their choice. The statement is attached to the Employment Agreement template. The statement must explain how the participant's health and safety will be protected if they choose to waive the criminal history background check. As a Support Broker, you are responsible for discussing the risks of waiving a criminal history background check with your employer.

Review *Appendix G* in reference to the Medicaid policy about criminal history background checks and waiving them. You will sign the waiver form with your employer indicating that you have addressed the issue with them. Community Support Workers listed on a state or federal provider exclusion list cannot provide paid supports.

Listed below are some reasons that your employer might get a criminal history background check completed on a person before hiring them as a Community Support Worker:

- The Community Support Worker will be working in the home or directly with the participant when no one else is around.
- The participant may keep cash in the home.
- The participant may be vulnerable to suggestions and may have been taken advantage of by people in the past.
- The Community Support Worker is not well known to the participant or their Circle of Support.

Listed below are some reasons that your employer might want to waive a criminal history background check:

- The Community Support Worker is employed for a short period of time to do a specific task and does not interact directly with the participant in their home.
- The Community Support Worker will not be in direct contact with the participant without someone else also being present at all times.
- The Community Support Worker is well known to the participant and their Circle of Support and there are no concerns.

Establishing Contracts

Establishing contracts may be one of the responsibilities of a Support Broker. Although Support Brokers will follow contracting guidelines that are established by the Idaho Department of Health and Welfare, there are important concepts that should govern how you work with Community Support Worker(s) or vendor(s) to develop reliable contracts.

Hiring

Now that your employer has identified a Community Support Worker and completed the Employment Agreement, the new employee needs to submit their entire packet, including either the criminal history check or the waiver of criminal history background check, to the Fiscal Employer Agent. Once this is done and the Fiscal Employer Agent has issued an employee ID number to the Community Support Worker, the Community Support Worker can begin working for the participant.

Helping Your Employer Get the Most from Their Employees

Review the *Guide to a Self-Directed Life* with your employer. The guide will help your employer find and keep the right worker.

Teaching the Participant to be a Good Employer

The Support Broker may be asked to help their employer supervise and monitor the Community Support Workers. Employers vary greatly in their ability to manage their employees. What can you do to help maximize your employer's ability to manage? You can help your employer become more independent in their role as an employer through:

- Developing a written list of rules and expectations of the employee.
- Reiterate that the Employment Agreement is an 'at will' contract and explain what it means to be an 'at will' employee.
- Review the terms and conditions of the Employment Agreement with your employer.
- Update job requirements as needed.
- Set up a regular time to discuss issues and concerns between the Community Support Worker and the employer.
- Keep written records of all meetings between the employer and the Community Support Worker.
- Establish review periods and decide what, and how, tasks will be reviewed (remind your employer to keep records of the reviews).
- Make sure that regular documentation is kept of hours worked and what services were provided.
- Encourage consistency regarding expectations of the Community Support Worker.

- Actively discourage any abuse or exploitation of the Community Support Worker, intentional or accidental, by the employer, and help your employer to keep personal boundaries.
- Encourage pro-active problem solving.
- Set up regular times and methods to reinforce positive work habits, attitudes, and task completion.
- Identify training opportunities for the Community Support Worker that are free or to which the employer can contribute.
- Set a good example; encourage your employer by modeling positive and pro-active communication with the Community Support Worker.

Monitor Your Employer's Satisfaction

You are expected to talk to your employer about their general satisfaction with their services on a regular basis. Build this into your routine visits. Handle problems immediately. IDAPA Rules state that the Support Broker will, 'submit documentation regarding the participant's satisfaction with identified supports as requested by the Department.' If the Community Support Worker is doing their job well, you and your employer should be able to document it. Use the Individual Experience Survey to record your employer's concerns and feelings. A template of the survey is attached in *Appendix D*. Listed below are some suggestions for using the Individual Experience Survey:

- Save the results of the survey, you may be asked to provide the results to the Department's Quality Assurance Team.
- Help your employer review the results with the Community Support Worker.
- The results of the survey can be used to discuss problems, concerns, or to justify raises.
- Use the results and the discussion to modify the Employment Agreement or specific tasks and plans, as needed.

Navigating the Future!
Review your employer's satisfaction with their Community Support Workers at least three (3) times a year. We recommend calendaring the reviews every three or four (3 – 4) months.

An annual individual participant review is conducted by the Department. This process ensures that participants continue to receive the right services for them. As a Support Broker, your work will also be monitored. Your employer will be asked to participate in a satisfaction survey conducted by the Department. Problems or issues regarding your performance as a Support Broker will be addressed by the Regional Quality Assurance Team.

Reviewing the Community Support Worker's Time Sheet

Your employer may ask you for help reviewing Community Support Worker time sheets. Your employer has to sign the time sheet before the Community Support Worker can get paid. The employer has the responsibility to make sure the time sheet accurately reflects dates, hours, and category of service actually provided. If they have trouble understanding the time sheet, help your employer with this task (you and your employer will need to have included this task on your Employment Agreement). Also, find out if there are natural supports that can help your employer or if you can provide training or aids which will allow them to become more independent. The time sheet includes date of service, times of service, and a service code. The codes are three digits and match the codes used on the Employment Agreement. A copy of a time sheet and instructions are included in *Appendix H*.

Remember; help your employer keep a file with copies of important documents. The employer needs to have copies of:

- The Support and Spending Plan Authorization sheet.
- All workers' Employment Agreements.

Check that the time sheet matches the other documents for category and code of service.

For example: If Bill Jones's Employment Agreement states he will perform chore services under the category of Personal Supports, the code is PSS, see *Appendix H*. This is the code that needs to be on the time sheet. If Bill uses JSS, he will not get paid.

Check the date(s) of service for accuracy. Did Bill clean the house on the date that is stated on the time sheet? If your employer is unsure, help them create a calendar or some other method to track when their workers come to work. Ask questions like, is Bill supposed to come once a week and when did he last come? Use your own observations to judge the situation. For example: Does the house look like it has been cleaned in the last week?

Check that the amount of hours for the service appears to be a reasonable match for the annual amount that has been allotted on the authorization sheet. If the authorization sheet states that chore services will cost $1,300 a year and your employer tells you that Bill is supposed to come once a week, and that he pays Bill $6.25 per hour, use a calculator to determine if the information is reflected accurately. Bill should be working about three hours a week. The time sheet should reflect that.

If something doesn't look right to you, ask your employer what they would like you to do about it. Encourage your employer to talk to their Circle of Supports. Help the employer and the circle look at options and resolve any problems. Do not take immediate responsibility or control of the situation unless:

- You think it will result in immediate threat to the health or safety of your employer.
- You think it constitutes Medicaid fraud.

In either of these cases, you must take immediate action. You are mandated to report abuse, neglect, or exploitation, and to report Medicaid fraud. Call Adult Protection or

law enforcement in the case of abuse, neglect, or exploitation, and call the Regional Care Manager if you suspect Medicaid fraud.

Immediate Risk to Health and Safety

You might discover that something that a worker is or is not doing can result in an immediate risk to the health and safety of your employer. A worker may be endangering your employer through specific behaviors on their part or omission of services. They may not have sufficient training or they may be purposefully exploiting your employer. Your employer might feel bad for reporting problems and you might only find out by reviewing time sheets. You have to report the problem if you think there is an immediate danger.

Nursing and other health related services may be essential to your employer's health and safety. If services are not being provided that should be, report your concerns immediately to your employer, their Circle of Support, and the Regional Care Manager.

Review the sections on Reporting Abuse, Neglect, and Exploitation of Vulnerable Adults, and the section on Complaints and Critical Incidents.

What to Do When Things Go Wrong

Worst Case Scenarios (That Have Actually Happened!)

The Community Support Worker:

- Gets arrested while providing services.
- Does not show up for work.
- Drops the participant off without making sure there is adequate supervision.
- Gets in a car wreck with the employer and does not report it.
- Does not report suspected abuse (by someone else).
- Quits unexpectedly.
- Comes late without prior notice.
- Takes their employer to an inappropriate setting without consent.
- Takes care of their own errands or tasks under the guise of providing therapy.
- Wears inappropriate clothing or engages in inappropriate behaviors.
- Comes to work intoxicated.
- Steals from the employer.
- Has sexual contact with the employer.
- Drives with the employer, without insurance.
- Abuse or neglect occurs while under the Community Support Worker's care.

Preparing for the Worst

Take preventive measures ahead of time. Remember, for each identified risk, identify at least three (3) back up plans. Use them as needed.

- Have a list of natural supports and phone numbers handy; use natural supports if possible when the workforce is not fully staffed.
    - If your employer doesn't have any natural supports, make a goal to develop some.

- Discuss possible crisis situations with your employer, their Circle of Support, and their Community Support Workers ahead of time. Prepare them to cope with emergencies, role-play, and identify hypothetical solutions.
- Create a list of community resources such as food banks, churches, senior centers, etc.
- Keep a file on substitute Community Support Workers; people who have passed the criminal history check and who want part-time work.
- Ensure your employer has an accessible method to get hold of you or a natural support as needed.
- Network with other Support Brokers to share resources.
- Call the local Council on Developmental Disabilities Self-Advocates at: (208) 334-2178. They can provide helpful advice and resources.
- Maintain a working relationship with the Regional Medicaid Care Manager and/or quality assurance staff; they may be able to help with additional resources.

You have a back-up plan, but things still go wrong

Now What?

- Is it an emergency or is it life threatening; if yes, call: 9-1-1, do not wait to see if you can handle this yourself.
- If the situation does not place your employer's health and safety in immediate danger, take the time to consult with your employer and their Circle of Support to identify a solution together.
- Recurring crises may indicate a need to submit a Change of Plan, need for an increase in specific services, or a change in the category of service.
- Abuse, neglect, exploitation, and abandonment issues must be reported immediately to either law enforcement or adult protection.
- Identify root causes and look for solutions.
- Respond positively to a crisis situation.
- Consider all pieces of the puzzle and be creative in your solutions.
- Ask questions.

Dismissing Staff

You may have to help your employer dismiss their Community Support Worker(s) which can be a painful, embarrassing, or difficult task. Remember to:

- Document.
  - Keep good records of the Satisfaction Surveys. If there are on-going problems with minor issues such as lateness, inappropriate behaviors or language, record them. If your employer gives a verbal warning or asks you to do it for them, put it in writing and ask your employer or their guardian to sign and date it.
- Get your employer or their guardian involved.
  - Except in cases which present a threat to health or safety, your employer makes the final decision. If they are uncomfortable with an attitude or behavior displayed by their Community Support Worker, talk about it with them, help them

to identify the issue, and encourage them to talk to the Community Support Worker about it.
    - Ask your employer to get feedback from their Circle of Support about the issues that concern them with a Community Support Worker.
- Attempt correction first.
    - If the issue is an on-going minor annoyance, which is not immediately threatening to safety or health, attempt a plan of correction first.
    - Encourage your employer to identify what action might resolve the problem and discuss it with the Community Support Worker.
    - Set a specific, measurable and objective benchmark, "Within the next month, you will not be more than ten (10) minutes late to work and you will call ahead of time if you are going to be late".
    - Write down the plan of correction and have everyone sign it.
- Be direct.
    - Stay calm, if you feel you are getting angry or defensive, stop the discussion.
    - Help your employer stay calm by being a good role model. End the conversation if your employer gets emotionally upset.
    - Stay objective while facilitating and assisting your employer.
    - If your employer wants help making a decision, remain objective and help them explore the "what if".
- Put it in writing.
    - If your employer decides that a Community Support Worker needs to be dismissed, help them put it in writing. It can be very simple and the employer does not need to give a reason if they do not want to. Date and have your employer sign the memo.
- Have a back up plan.
    - Make sure you have a back up plan. When a Community Support Worker is dismissed it will leave a gap in the services your employer needs, you may have to help fill this gap.

Reporting Abuse, Neglect, and/or Exploitation

Idaho Statutes; *Title 39; Health and Safety Chapter 53; Adult Abuse, Neglect and Exploitation Act; 39-5303. Duty to Report Cases of Abuse, Neglect or exploitation of Vulnerable Adults*.

(1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, ombudsman for the elderly, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-1301(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency.

(2) Failure to report as provided under this section is a misdemeanor subject to punishment as provided in section 18-113, Idaho Code…Any action taken by the department pursuant to this subsection shall be appealable as provided in chapter 52, title 67, Idaho Code.
(3) Any person, including any officer or employee of a financial institution, who has reasonable cause to believe that a vulnerable adult is being abused, neglected or exploited may report such information to the commission or its contractors.
(4) The commission and its contractors shall make training available to officers and employees of financial institutions in identifying and reporting instances of abuse, neglect or exploitation involving vulnerable adults.
(5) Any person who makes any report pursuant to this chapter, or who testifies in any administrative or judicial proceeding arising from such report, or who is authorized to provide supportive or emergency services pursuant to the provisions of this chapter, shall be immune from any civil or criminal liability on account of such report, testimony or services provided in good faith, except that such immunity shall not extend to perjury, reports made in bad faith or with malicious purpose nor, in the case of provision of services, in the presence of gross negligence under the existing circumstances.
(6) Any person who makes a report or allegation in bad faith, with malice or knowing it to be false, shall be liable to the party against whom the report was made for the amount of actual damages sustained or statutory damages in the amount of five hundred dollars ($500), whichever is greater, plus attorney's fees and costs of suit. If the court finds that the defendant acted with malice or oppression, the court may award treble actual damages or treble statutory damages, whichever is greater.

Warning Signs that a Vulnerable Adult May be a Victim of Abuse, Neglect, or Exploitation

These ‘warning signs’ should not be interpreted as proof that abuse, neglect, or exploitation is occurring. They should serve as indicators that a problem may exist and a report should be made to law enforcement or to the local Adult Protection Service, Community Support Worker, or Vendor.

Physical Indications

- An injury that has not received medical attention or that has not been properly cared for.
- An injury that is inconsistent with the explanation for its cause.
- An indication of pain or discomfort at being touched.
- Cuts, burns, puncture wounds, scratches, bruises, or welts anywhere on the body of the participant.
- An appearance of dehydration or malnutrition when there is no known cause of such condition.
- A sallow complexion or otherwise abnormal skin coloration.
- Dark circles around eyes, sunken eyes, or cheeks.

- Misuse of medication or inappropriate administration of medication by a caregiver.
- Soiled clothing or bed linens.
- 'Doctor shopping,' (i.e., frequent use of hospital emergency rooms or different doctors, Community Support Worker(s), or vendor(s)).
- Chronic lack of necessities such as food, running water, heat, or electricity.
- Chronic lack of personal items such as a comb, soap, clean clothes, etc.
- Imposed isolation (i.e. the participant is discouraged or prevented by a caregiver or other family member from attending community events, church, the senior center, or from seeing friends and neighbors).

Behavioral Indications

- Fear.
- Anxiety, agitation.
- Anger.
- Withdrawal.
- Depression.
- Non-responsiveness, resignation, ambivalence.
- Excuses or implausible explanations, contradictory statements.
- Reluctance or hesitation to discuss certain subjects or to talk about a caregiver, family member, or other person on which the participant is dependent.
- Confusion, disorientation.

Suspect Caregiver Behavior

- Prevents the participant from speaking to or seeing visitors.
- Displays anger, indifference, aggression, or sexually suggestive behavior toward the participant.
- Has a history of substance abuse, sexual predation, mental illness, criminal behavior, or family violence.
- Presents a 'cold' demeanor (i.e. shows no affection, or is openly disrespectful of the participant).
- Flirts or uses sexual innuendo to communicate with the participant.
- Makes conflicting statements or offers implausible explanations regarding the participant's injuries or condition.
- Describes the participant as a burden or nuisance.

Indications of Exploitation

- Frequent expensive gifts to the caregiver from the participant.
- The participant's personal papers, credit cards, checks, or savings account paperwork is missing.
- The caregiver's name has recently been added to a bank account, deed, or title to property belonging to the participant.
- The participant has numerous unpaid bills.
- There is a new or recently revised will, but the participant is physically or cognitively incapable of writing or revising such a document.
- The participant has no concept of how much monthly income they receive.

- The participant’s signature appears on a loan application.
- There are frequent checks for "cash" drawn on the participant’s account (or frequent ATM withdrawals).
- There are irregularities on the participant’s tax return.
- The caregiver refuses to allow the participant to spend their own money.
- Signatures on checks or other documents which are allegedly those of the participant do not resemble that participant's known signature or are otherwise suspicious in appearance.

CHAPTER SEVEN: CONTINUING DUTIES FOR THE SUPPORT BROKER

Maintain Regular Contact

Make sure your employer can easily contact you in case of an emergency. Have a back up plan in case you are unavailable.

Documentation

- Maintain documentation. The Bureau of Developmental Disabilities employs Quality Assurance/Quality Improvement Specialists and may ask you to provide them with proof that you are performing your job.
- Document services you provide to help your employer self-direct.
- Document in writing, all of your contacts with your employer by phone, mail, email, or in person (it is recommended that you meet with your employer at least quarterly to review their satisfaction with services).
- Note in your document what took place during the contact, how long it lasted, and if there were any issues or concerns.
- Document in writing, all your contacts with your employer's Circle of Support.
- Document in writing, all meetings with Community Support Workers.
- Document in writing, any complaints about anything.
- Your record should include the following information:
  - Date.
  - Who participated.
  - Purpose or reason.
  - Brief summary of discussion.
  - Outcome.
  - Time spent.
  - Appropriate signature(s).

Q: When is a plan change necessary?
A: Any shift in money from one category to another requires a plan change. Adding a new service, task, or good, or deletion of a service which has a safety plan attached to it requires a plan change. A plan change which results in a change to a community support worker's wage, duties or service category requires a new employment agreement.

Plan Changes

Request for New Budget Allocation

Participants can request a new budget allocation if they have had a change in condition which requires an increase in supports that cannot be met by the existing budget allocation. If a participant and the Support Broker believe this is the case they must submit to the Regional Medicaid Office any information and/or supporting documentation which verifies that a significant change in condition has occurred.

What Happens When a Plan Change Is Submitted

- The Regional Medicaid Care Manager receives a plan change request.
- The Regional Medicaid Care Manager will review the plan change request within five (5) business days of its receipt.
- The Regional Medicaid Care Manager will review the plan change request to determine whether the support, good, and/or service meets the criteria for allowable expenses and falls within the individualized budget.
- The Regional Medicaid Care Manager reviews the plan change request to ensure that risk factors are adequately identified and safety plans are provided for each risk.
- A Budget Authorization Sheet must be submitted listing the new service, task, or good requested.

Approval of the Plan Change Request

- Regional Medicaid Services will notify Idaho Center for Disabilities Evaluation that the participant has been approved for reassessment, to determine new budget allocation for a new annual plan.
- Idaho Center for Disabilities Evaluation will complete the reassessment and budget determination according to the standard business model for determining an individual budget allocation.
- Idaho Center for Disabilities Evaluation will communicate the new budget determination to the participant, Support Broker, and the Regional Medicaid Office.
- The Regional Medicaid Care Manager will send a copy of the approved plan change to the participant and their Support Broker.
- The Regional Medicaid Care Manager will send a copy of the approved Budget Summary Sheet relevant to the plan change to the Fiscal Employer Agent listing the additional budget allocations.

Denying the Significant Change in Condition

If the documentation does not indicate there has been a significant change in the participant's condition, Regional Medicaid Services will send a notice to the participant and the Support Broker notifying them that the documentation does not support a significant change in condition.

- This letter will identify reasons why the plan change cannot be approved, will include instructions for re-submitting if modifications are made, and instructions to request a Reconsideration of Denial should the participant decide they do not want to modify and re-submit the plan change.
- The participant has twenty-eight (28) days to request a Reconsideration of Denial.
- If a participant files a Notice of Reconsideration of Denial, the Division of Medicaid has fifteen (15) days to review it and make a determination.
- If the participant does not appeal the denial within twenty-eight (28) days, the plan change will be filed as denied.
- If the participant does appeal within twenty-eight (28) days, the Rules Governing Case Proceedings and Declaratory Rulings, Idaho Administrative Procedures Act (IDAPA) 16.05.03, will be followed.

Reconsideration of Denial

- The participant submits a request for a Reconsideration of Denial to the Regional Medicaid Office.
- Regional Medicaid Office forwards the request for a Reconsideration of Denial to the Division of Medicaid, Bureau of Developmental Disability Services, within five (5) business days of receipt.
- The Division of Medicaid, Bureau of Developmental Disability Services, has fifteen (15) business days from the date of receipt of the Reconsideration of Denial to request supporting documentation to complete the review, decide the matter, and notify the participant of their decision.

Notice of Reconsideration

- After fifteen (15) days the Division of Medicaid will send a Notice of Reconsideration of Denial for Services letter to the participant, with a copy of the letter to the Support Broker and the Regional Medicaid Care Manager.
- If the Division of Medicaid overturns a regional decision to deny a plan change, the Regional Medicaid Care Manager will complete the following within three (3) business days:
  - Send the participant and Support Broker a copy of the approved plan change.
  - Send a copy of the Budget Summary Sheet relevant to the plan change to the Fiscal Employer Agent.
  - The Regional Medicaid Care Manager will provide prior authorization for the budget associated with the approved plan change (if applicable).
- If the Division of Medicaid upholds a regional decision to deny a plan change, the Division of Medicaid will send a letter of denial to the participant, their Support Broker, and a copy to the Regional Medicaid Office.

Denying the Significant Change in Condition

If the documentation does not indicate there has been a significant change in the participant's condition, Regional Medicaid Services will send a notice to the participant and the Support Broker notifying them that the documentation does not support a significant change in condition.

- This letter will identify reasons why the plan change cannot be approved, will include instructions for re-submitting if modifications are made, and instructions to request a Reconsideration of Denial should the participant decide they do not want to modify and re-submit the plan change.
- The participant has twenty-eight (28) days to request a Reconsideration of Denial.
- If a participant files a Notice of Reconsideration of Denial, the Division of Medicaid has fifteen (15) days to review it and make a determination.
- If the participant does not appeal the denial within twenty-eight (28) days, the plan change will be filed as denied.
- If the participant does appeal within twenty-eight (28) days, the Rules Governing Case Proceedings and Declaratory Rulings, Idaho Administrative Procedures Act (IDAPA) 16.05.03, will be followed.

Reconsideration of Denial

- The participant submits a request for a Reconsideration of Denial to the Regional Medicaid Office.
- Regional Medicaid Office forwards the request for a Reconsideration of Denial to the Division of Medicaid, Bureau of Developmental Disability Services, within five (5) business days of receipt.
- The Division of Medicaid, Bureau of Developmental Disability Services, has fifteen (15) business days from the date of receipt of the Reconsideration of Denial to request supporting documentation to complete the review, decide the matter, and notify the participant of their decision.

Notice of Reconsideration

- After fifteen (15) days the Division of Medicaid will send a Notice of Reconsideration of Denial for Services letter to the participant, with a copy of the letter to the Support Broker and the Regional Medicaid Care Manager.
- If the Division of Medicaid overturns a regional decision to deny a plan change, the Regional Medicaid Care Manager will complete the following within three (3) business days:
  - Send the participant and Support Broker a copy of the approved plan change.
  - Send a copy of the Budget Summary Sheet relevant to the plan change to the Fiscal Employer Agent.
  - The Regional Medicaid Care Manager will provide prior authorization for the budget associated with the approved plan change (if applicable).
- If the Division of Medicaid upholds a regional decision to deny a plan change, the Division of Medicaid will send a letter of denial to the participant, their Support Broker, and a copy to the Regional Medicaid Office.

Denying the Significant Change in Condition

If the documentation does not indicate there has been a significant change in the participant's condition, Regional Medicaid Services will send a notice to the participant and the Support Broker notifying them that the documentation does not support a significant change in condition.

- This letter will identify reasons why the plan change cannot be approved, will include instructions for re-submitting if modifications are made, and instructions to request a Reconsideration of Denial should the participant decide they do not want to modify and re-submit the plan change.
- The participant has twenty-eight (28) days to request a Reconsideration of Denial.
- If a participant files a Notice of Reconsideration of Denial, the Division of Medicaid has fifteen (15) days to review it and make a determination.
- If the participant does not appeal the denial within twenty-eight (28) days, the plan change will be filed as denied.
- If the participant does appeal within twenty-eight (28) days, the Rules Governing Case Proceedings and Declaratory Rulings, Idaho Administrative Procedures Act (IDAPA) 16.05.03, will be followed.

Reconsideration of Denial

- The participant submits a request for a Reconsideration of Denial to the Regional Medicaid Office.
- Regional Medicaid Office forwards the request for a Reconsideration of Denial to the Division of Medicaid, Bureau of Developmental Disability Services, within five (5) business days of receipt.
- The Division of Medicaid, Bureau of Developmental Disability Services, has fifteen (15) business days from the date of receipt of the Reconsideration of Denial to request supporting documentation to complete the review, decide the matter, and notify the participant of their decision.

Notice of Reconsideration

- After fifteen (15) days the Division of Medicaid will send a Notice of Reconsideration of Denial for Services letter to the participant, with a copy of the letter to the Support Broker and the Regional Medicaid Care Manager.
- If the Division of Medicaid overturns a regional decision to deny a plan change, the Regional Medicaid Care Manager will complete the following within three (3) business days:
  - Send the participant and Support Broker a copy of the approved plan change.
  - Send a copy of the Budget Summary Sheet relevant to the plan change to the Fiscal Employer Agent.
  - The Regional Medicaid Care Manager will provide prior authorization for the budget associated with the approved plan change (if applicable).
- If the Division of Medicaid upholds a regional decision to deny a plan change, the Division of Medicaid will send a letter of denial to the participant, their Support Broker, and a copy to the Regional Medicaid Office.

Budget Oversight

One of your job duties as a Support Broker is to help your employer monitor and review their Self-Direction budget. Your employer can lose their right to participate in Self-Direction if they cannot stay within their budget.

Your employer will get a monthly statement from the Fiscal Employer Agent. The statement will include an account of what they have spent each month and how much money is left in the budget. The statement will include specific amounts for each bill that has been paid on their behalf. The Employment and Vendor Agreements state the details of how much money can be spent on each specific support and service. The Fiscal Employer Agent will match the bills they pay to those agreements. If they don't match, are over the authorized amount, or the amount of money for a specific service has been exhausted, the bill will not be paid.

You need to review each monthly statement with your employer and match it to the amount that has been budgeted for each specific support and service. It is your job to help your employer resolve any difficulties. Find a good way to visually show your employer how much money they are spending and how much they have remaining each month. There are many types of budgeting tools on the market. Use what works best for your employer.

Annual Re-Determination

Your employer will be evaluated annually to determine if they still meet the criteria for waiver services. You will need to help them in this process. Approximately one hundred and twenty (120) days before the end of their annual plan, your employer will get a letter from the Idaho Center for Disabilities Evaluation. This letter will inform your employer of what they need to do in order to continue their Medicaid adult services for another year.

Your employer will need to schedule an appointment with the Independent Assessment Provider to review the past year and update their medical and social histories. They may need to go through a new evaluation of their functional abilities. The evaluation tool that is used for this purpose is called the Scales of Independent Behavior – Revised. The Scales of Independent Behavior - Revised is used to determine if a participant meets waiver level of care criteria, according to IDAPA Rule.

Your employer may find out that they are no longer eligible for Developmental Disability Waiver services. If this happens, they will no longer be eligible for the Self-Direction Program. They can appeal this decision and maintain their current level of services while going through the appeal process. However, you still need to help them prepare to transition out of the level of services they are getting.

If your employer remains eligible for Developmental Disability Waiver Services, they may choose to return to the traditional path. They may want to get residential habilitation or community supported employment through an agency. They may want to have an agency hire and train their workers. If they and their Circle of Support want to choose

this option, they may choose a Plan Developer to work with them instead of a Support Broker. Please review the next chapter, *Transitions,* for more information.

If your employer wants to stay in the Self-Direction Program, they will continue to need a Support Broker. They will need to develop a new Support and Spending Plan for the following year. The Independent Assessment Provider will give them their new annual budget and the plan will need to be within their allocated budget.

Your Employer's Responsibilities

Another task that you have is to help your employer meet their responsibilities as a Self-Directed participant. These duties are clearly outlined in both this *Support Broker Handbook* and IDAPA Rules. To summarize, the participant agrees to the following:

- Accept the guiding principles of the Self-Direction Program.
- Participate in person-centered planning meetings.
- Negotiate payment rates for paid community supports and services.
- Complete agreements for the Fiscal Employer Agent, the Support Broker, and Community Support Worker services. Submit those agreements to the Fiscal Employer Agent on Department approved forms.
- Ensure that Employment Agreements contain sufficient detail for the type of support/service that is being purchased.
- Develop a comprehensive Support and Spending Plan.
- Review and verify time sheets and bills.
- Participate in the quality assurance process.

Your Employer's Health and Safety

By becoming a Support Broker you are also agreeing to help your employer protect their health and safety. You do this by identifying risk factors, developing safety plans, developing backup plans, and mitigating risks whenever possible. You are responsible for communicating with the appropriate authorities if you believe your employer's health or safety is being threatened. This responsibility includes reporting if your employer is threatening their own health or safety in any way. They may be refusing to take medication or living in an unsafe environment. They may have given all their food to a friend and have no money left to buy more. They may be acting disoriented or confused and refusing to go to the doctor. In a non-life threatening situation, you can call on a guardian, other natural support, or contact a Department staff member. In a life-threatening situation, you should immediately contact emergency services or law enforcement.

Complaints and Critical Incident Reporting

A complaint is a statement of dissatisfaction with services. A critical incident is a serious situation which results in an immediate threat to your employer's health, safety, or well being.

A critical incident needs to be reported to the Circle of Support, the Regional Care Manager, and emergency services immediately. Critical incidents include the following:

death, attempted suicide, substantiated abuse and neglect, unusual restraint, fiscal fraud, break-in and burglary, over-dose of medication, or similar events.

An accident is a mishap or mistake which did not occur as a result of any purpose or intent. If an accident occurs that has physical, emotional, or legal ramifications for your employer, it must be reported to their guardian. If your employer is their own guardian, you need to talk with them to determine whether family members need to be notified.

Review the policy on complaint/critical incident reporting in *Appendix G*. Use the Critical Incident and Complaint Forms in *Appendix F* to report issues. The Critical Incident Form is used to report the following:

- Psychological or emotional upset to your employer.
- Involvement with legal authorities.
- Unusual or extreme changes in habits, appearance, or state of mind in your employer.
- Anything else you think should be documented under this heading.

Maintain the Circle of Support

An on-going part of your job is to maintain and develop your employer's Circle of Support. Give each person your phone number and make sure you have theirs. Schedule regular contact times to up date family members, friends, community members, advocates, and others who form the natural support system. Your employer may want to have regular meetings, phone calls, email, or choose a more informal method of continuing contact. You will need to meet with the Circle of Support several times a year, to work on the Support and Spending Plan, up date the budget information, discuss changes in services or needs, or talk about the future. Look for opportunities to expand the circle. Are there people in the community who appear interested or ask questions about your employer or the Self-Direction Program? Does your employer regularly attend any community activities? If not, try to find some that they would like to attend. There are many low-cost and free activities everywhere. Call local churches, community centers, non-profits, libraries, and adult education centers. All of these facilities offer opportunities to meet and develop natural supports.

CHAPTER EIGHT: TRANSITIONING OUT OF SELF-DIRECTED COMMUNITY SUPPORTS OPTION

Voluntary Transitions: A Return to a Traditional Waiver Program

A participant can return to traditional Developmental Disability Waiver Services by contacting the Regional Medicaid Care Manager and stating they want to discontinue their participation in the Self-Directed Community Supports option.

If your employer wants to return to the traditional Waiver pathway, the Regional Care Manager will complete intake and presumptive eligibility.

Your employer will need to designate a Plan Developer, either paid or unpaid, to help them with the planning process. The Plan Developer will help the person complete a one hundred and twenty (120) day transition plan, using the standard participant Support Plan(s).

The Care Manager will complete the following processes based on the needs of the participant:

- Prior authorize community crisis supports to provide for any immediate crisis. The Crisis Resolution Plan must identify ways to prevent ongoing crisis.
- Approve the one hundred and twenty (120) day transition plan to include the Participant Support Plan signature page and the Participant Support Plan. Supports and Services Authorization costing page must be completed and submitted prior to the Regional Medicaid Care Manager approving a transition plan for implementation.
- Prior authorize services identified on the costing page. Services identified on the plan will be prior authorized from the date the one hundred and twenty (120) transition plan was approved once the Medical Care Evaluation, the Health and Well-Being form, and the Participant Support Plan have been submitted to the Regional Medicaid Care Manager.
- The Regional Medicaid Care Manager will contact the Independent Assessor to notify them to begin the formal eligibility process.
- The Regional Medicaid Care Manager will send a letter to the participant notifying them that their one hundred and twenty (120) day plan has been approved.

The Independent Assessment Provider will Follow Their Usual Process

- The Independent Assessment Provider verifies participant's Developmental Disability and waiver eligibility using the traditional business model for Annual Re-Determination of Program Eligibility.
- If the participant is determined to have a Developmental Disability and is waiver eligible, letter(s) approving eligibility are sent to the participant.
- Once eligibility has been determined, the process for obtaining traditional services after the one hundred and twenty (120) day transition plan has expired will occur according to the existing business model.

Involuntary Transition from the Self-Directed Community Supports Option

Q: What qualifies as a crisis transition?

A: Crisis transitions happen when an event or process occurs which jeopardizes the participant's health or safety.

The Department may choose to remove a person from the Self–Directed Community Supports option if one or more of the following requirement events occur:

- Required Supports: The participant is not willing to work with the Support Broker and a Fiscal Employment Agent.
- Support and Spending Plan: The participant's Support and Spending Plan is not being followed.
- Risk and Safety Back-up Plans: Back-up plans to monitor health and safety are not being followed.
- Health and Safety Choices: The participant's choices directly endanger their own health, welfare, safety, or endanger or harm others.

No Immediate Jeopardy to Health and Safety

If there is no immediate jeopardy to the health or safety of the participant, the Department will send a letter by certified mail notifying them of the concerns. The letter will state that the participant will be removed from the Self-Directed option unless certain identified health and/or safety concerns are remedied. The letter will list the specific concerns and the date by which a plan of correction needs to be submitted. The letter will allow the participant ten (10) business days to submit a plan of correction.

After receiving the letter, the participant can pursue one (1) of the following options:

- Option 1: Participant submits a Plan of Correction to the Regional Medicaid Care Manager within ten (10) days.
- Option 2: Participant does not submit a Plan of Correction to the Regional Medicaid Care Manager within ten (10) days.

Option 1: Participant Submits a Plan of Correction

The Regional Medicaid Office reviews the plan to determine whether health and/or safety concerns have been remedied. The Regional Medicaid Office will either approve or deny the Plan of Correction:

Approved Plan of Correction

- The Regional Medicaid Office sends a letter to the participant and Support Broker notifying them that the Plan of Correction has been approved.
- The Regional Medicaid Office monitors implementation of the Plan of Correction through quality assurance processes.

Denied Plan of Correction

- The Regional Medicaid Office will send a letter by certified mail, return receipt requested, to the participant and their Support Broker stating the Plan of Correction has been denied and the participant is being removed from the Self-Directed Community Supports Option. The letter will include the date the removal will be effective and the appeals process.
- The Regional Medicaid Office will determine presumptive eligibility on the participant. The participant is presumed eligible when there is documentation that validates developmental disability eligibility and Intermediate Care Facility for the Mentally Retarded level of care waiver eligibility. Information to verify eligibility may be obtained from old Department records, Developmental Disabilities Agency records, and the Idaho Center for Disabilities Evaluation.
- If the participant meets presumptive eligibility, the Regional Medicaid Office will complete the following processes based on the specific needs of the participant:
  - Prior authorize community crisis supports.
  - Coordinate with the participant and their Circle of Support to develop a one hundred and twenty (120) day transition plan. The current participant Service Plan format is used for the one hundred and twenty (120) day plan. This plan must contain those services and supports that will allow the participant to live safely in the community.
- The Regional Medicaid Office will review the transition plan, and if modifications are required prior to approval, the Regional Medicaid Office will communicate with the Plan Developer about the needed changes.
- The Regional Medicaid Office will prior authorize services identified on the one hundred and twenty (120) day transition plan authorization page. Services identified on the plan will be prior authorized back to the date the one hundred and twenty (120) day transition plan was approved, once all of the following documents have been submitted to Regional Medicaid Office:
  - Participant Service Plan.
  - Participant Service Plan Signature Page.
  - Participant Service Plan Supports and Services Authorization Page.
  - Medical Care Evaluation.
  - Health and Well-Being form.

- Idaho Center for Disabilities Evaluation verifies participant's Developmental Disability and waiver eligibility using the traditional business model for Annual Re-determination of Program Eligibility.
- If a participant is determined to be Developmentally Disabled and waiver eligible, the Idaho Center for Disabilities Evaluation will send a letter to the participant approving eligibility.

Option 2. Participant Doesn't Submit a Plan of Correction

- The Regional Medicaid Office sends a letter by certified mail, return receipt requested, to the participant and their Support Broker stating the Plan of Correction has been denied and the participant is being removed from the Self-Directed Community Supports Option. The letter will include the date the removal will be effective and the appeals process.
- The Regional Medicaid Office will complete the intake process and presumptive eligibility. The participant is presumed eligible when there is documentation that validates developmental disability eligibility and Intermediate Care Facility for the Mentally Retarded level of care waiver eligibility. Information to verify eligibility may be obtained from old Department records, Developmental Disabilities Agency records, and the Idaho Center for Disabilities Evaluation.
- If the participant meets presumptive eligibility, the Regional Medicaid Office will complete the following processes based on the specific needs of the participant:
  - Prior authorize community crisis supports.
  - Coordinate with the participant and Circle of Support to develop a one hundred and twenty (120) day transition plan. The current participant service plan format is used for the one hundred and twenty (120) day plan. This plan must contain those services and supports that will allow the participant to live safely in the community.
- The Regional Medicaid Office reviews the transition plan and if modifications are required prior to approval, the Regional Medicaid Office will communicate with the Plan Developer about needed changes.
- The Regional Medicaid Office prior authorizes services identified on the one hundred and twenty (120) day transition Plan Authorization page. Services identified on the transition plan will be prior authorized back to the date the one hundred and twenty (120) day transition plan was approved once all of the following documents have been submitted to the Regional Medicaid Office:
  - Participant Service Plan.
  - Participant Service Plan Signature page.
  - Participant Service Plan Supports and Services Authorization page.
  - Medical Care Evaluation.
  - Health and Well-Being form.
- Idaho Center for Disabilities Evaluation verifies participant's Developmental Disability and waiver eligibility using the traditional business model for Annual Re-Determination of Program Eligibility.
- If a participant is determined to be Developmentally Disabled and waiver eligible, The Idaho Center for Disabilities Evaluation will send a letter to the participant approving eligibility.

Immediate Jeopardy to Health and/or Safety

If the Department determines there is reason to immediately remove a participant from the Self-Directed Community Supports Option, the Regional Medicaid Care Manager sends a letter by certified mail to the participant and their Support Broker indicating that the participant is being removed from the Self-Directed Community Supports Option and when the removal will become effective. The Regional Medicaid Care Manager will initiate the presumptive eligibility process. If the participant is found to be eligible for waiver services, the Regional Medicaid Care Manager will initiate a one hundred and twenty (120) day presumptive eligibility transition plan with the participant and their Circle of Support.

Termination of Support Broker Services

According to Idaho Administrative Procedures Act (IDAPA) 16.03.13, if a support broker decides to end services with a participant, he must give the participant at least thirty (30) days' written notice prior to terminating services. The support broker must assist the participant to identify a new support broker and provide the participant and new support broker with a written service transition plan by the date of termination. The Transition plan must include an updated Support and Spending Plan that reflects current supports being received, details about the existing community support workers, and unmet needs.

A Participant Wants To Access the Self-Directed Option Mid-Plan Year

If a participant wants to access the Self-Directed Option before the usual annual re-determination date, they need to contact the Regional Medicaid Care Manager and request information about the program. The Regional Medicaid Care Manager will send them an informational brochure. If the participant is still interested after reviewing the brochure, they need to contact the Regional Medicaid Care Manager again to schedule an appointment for an orientation meeting. The Regional Medicaid Care Manager will help the participant with the application process.

CHAPTER NINE: EMPLOYER RESPONSIBILITIES

Your employer wants to be able to make choices about what services they get, and who and how those services are provided. As a Support Broker, part of your job is to help your employer participate by communicating their wants and needs. They are not a silent partner in the Self-Direction process.

IDAPA Rules - Consumer-Directed Services

Idaho Administrative Procedures Act (IDAPA) rules 16.03.13 state, with the assistance of the support broker and the legal representative, if one exists, the participant is responsible for the following:

01. Guiding Principles. Accepting and honoring the guiding principles for the SDCS [Self-Directed Community supports] option…
02. Person-Centered Planning. Participating in the person-center planning process in order to identify and document support and service needs, wants, and preferences.
03. Rates. Negotiating payment rates for all paid community supports he wants to purchase, ensuring rates negotiated for supports and services do not exceed the prevailing market rate, and including the details in the employment agreements.
04. Agreements. Completing and implementing agreements for the fiscal employer agent, the support broker and community support workers and submitting the agreements to the fiscal employer agent. These agreements must be submitted on Department-approved forms.
05. Agreement Detail. Ensuring the employment agreements specifically identify the type of support being purchased, the rate negotiated for the support, and the frequency and duration of the scheduled support or service. The participant is responsible for ensuring that each employment agreement: clearly identifies the qualifications needed to provide the support or service; includes a statement signed by the hired worker that he possesses the needed skills; and the signature of the participant that verifies the same. Additionally, each employment agreement will include statements that: the participant is the employer even though payment comes from a third party; employees are under the direction and control of the participant; and no employer-related claims will be filed against the Department.
06. Plan. Developing a comprehensive Support and Spending Plan based on the information gathered during the person-centered planning.

07. Timesheets and Invoices. Reviewing and verifying that supports being billed were provided and indicating that he approves of the bill by signing the timesheet or invoice.
08. Quality Assurance and Improvement. Providing feedback to the best of his ability regarding his satisfaction with the supports he receives and the performance of his workers.

To participate and become an employer, the participant must:

- Qualify for the Developmental Disability Waiver.
- Fully understand the rights and responsibilities of the Self-Direction Option.
- Be willing to participate in any and all training in regards to being an employer on the Self-Directed Community Supports Waiver Option of the Developmental Disability Waiver.

The employer and their Circle of Support will:

- Follow accepted employment practices and not discriminate against any Support Broker based upon race, color, religion, marital status, national origin, or age.
- Follow accepted employment practices regarding harassment of employees including the Support Broker. Harassment can take many forms. Signs of harassment may include: words, signs, jokes, pranks, intimidation, or physical contact.
- Follow accepted employment practices regarding sexual harassment of employees including the Support Broker. Sexually harassing conduct may include unwelcome sexual advances, requests for sexual favors, or any other verbal or physical contact of a sexual nature that prevents the Support Broker from performing their duties or creates an intimidating, hostile, or offensive working environment.
- Complete an employment agreement with the Support Broker. The agreement will include: fixed hourly rate, type, frequency, and duration of services provided by the Support Broker.
- Will be actively involved in the Person Centered Planning meeting.
- Will help the Support Broker develop a written Support and Spending Plan.
- Will verify hours worked by the Support Broker.
- Will help the Support Broker in any and all community support agreements that are written.
- Will retain a copy of any documentation at the employer's home.
- Will help the Support Broker monitor their budget.
- Will participate with the Department's quality assurances measures as requested.

Please refer to the *Guide to a Self-Directed Life* for more information on your employer's responsibilities.

GLOSSARY OF ACRONYMS AND DEFINITIONS

COMMUNITY SUPPORT WORKER: A participant, agency, or vendor selected and paid by the participant to provide Community Support Worker Services.

CRIMINAL HISTORY CHECK: A Support Broker must comply with IDAPA 16.05.06: Rules Governing criminal history and background checks.

DEPARTMENT: This term refers to the Department of Health and Welfare.

FISCAL EMPLOYER AGENT: An agency that provides Financial Management Services to participants who have chosen the Self-Directed Community Supports option.

FISCAL MANAGEMENT SERVICES: Services provided by a Fiscal Employer Agent.

INDEPENDENT ASSESSMENT PROVIDER: An assessment for program eligibility may be performed by either the Department or its designee. The purpose of the assessment is to determine a participant's eligibility for developmental disabilities services in accordance with Section 66-402, Idaho Code, and for Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded level of care for waiver services in accordance with IDAPA 16.03.10, "Rules Governing the Medicaid Enhanced Plan Benefits," Sections 322 through 328, (2006). Only participants who are eligible for Intermediate Care Facility for the Mentally Retarded level of care for waiver services meet criteria for the Self-Directed Community Supports option.

IDAHO CENTER FOR DISABILITIES EVALUATION: The designated contractor used by the Department of Health and Welfare to determine eligibility for adult developmental disabilities services.

INTERMEDIATE CARE FACILITY (FOR DEVELOPMENTALLY DISABLED)/ MENTALLY RETARDED: This refers to both a specific type of institution and an amount of payment for a specific level of care.

INDIVIDUAL SUPPORT PLAN: This refers to the plan that is developed by participants in the traditional Developmentally Disabled Waiver Program.

MY VOICE MY CHOICE: The participant workbook for the Self-Directed Community Supports option.

PARTICIPANT EXPERIENCE SURVEY: This series of questions is used to monitor and discuss participant satisfaction with their ability to self-direct their services.

REGIONAL MEDICAID SERVICES: Medicaid services are available through the local offices in each Department region. There are seven (7) regions in Idaho.

SUPPORT BROKER: An individual who is hired by and advocates on behalf of the participant to provide Support Broker services

SELF DIRECTION: The program option which offers consumer-directed services to participants who meet criteria for Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded Waiver Level of Care for developmental disabilities services.

SELF-DIRECTED COMMUNITY SUPPORTS OPTION:

SCALES OF INDEPENDENT BEHAVIOR – REVISED: An assessment tool used to gauge the age-equivalency of a person's functional abilities.

SUPPORT AND SPENDING PLAN: The tool used to calculate the participant's expenses for each support and service.

REGIONAL OFFICES

Region 1

Address		Phone Number
1120 Ironwood Drive Coeur d' Alene, Idaho 83814-2607	FAX	(208) 769-1567 (208) 666-6856

Region 2

Address		Phone Number
1118 F Street P. O. Drawer B Lewiston, Idaho 83501	FAX	(208) 799-4400 (208) 799-5167

Region 3

Address		Phone Number
3402 Franklin Road Caldwell, Idaho 83605	FAX	(208) 455-7152 (208) 454-7625

Region 4

Address		Phone Number
1720 Westgate Drive Boise, Idaho 83704	FAX	(208) 334-6700 (208) 334-0901

Region 5

Address		Phone Number
601 Pole Line Road, Suite 3 Twin Falls, ID 83301	FAX	(208) 736-1482 (208) 736-2116

Region 6

Address		Phone Number
1070 Hiline Road Pocatello, Idaho 83205-4166	FAX	(208) 239-6266 (208) 293-6269

Region 7

Address		Phone Number
150 Shoup, Suite 19 Idaho Falls, Idaho 83402	FAX	(208) 528-5964 (208) 528-5756

APPENDIX A

Guidelines for Allowable and Non-Allowable Expenses

The purchase of supports and services must meet federal medical assistance regulations including all of the following criteria:

- Must be required to meet the identified needs and outcomes in the participant's Support and Spending Plan and assure the health, safety, and welfare of the participant.
- Must collectively provide a feasible alternative to an institution.
- Must be the least costly alternative that reasonably meets the participant's identified needs.
- Must be for the sole benefit of the participant.

If all of the above criteria are met, supports and services are appropriate purchases when they are reasonably necessary to meet the following participant outcomes:

- Maintain the ability of the participant to remain in the community.
- Enhance community inclusion and family involvement.
- Develop or maintain personal, social, physical, or work related skills.
- Decrease dependency on formal support services.
- Increase independence of the participant.
- Increase the ability of unpaid family members and friends to receive training and education needed to provide support.

Allowable Expenses

Through the Self-Direction option, participants are able to obtain supports and services in ways that are meaningful to them and are able to customize supports to best meet identified needs. The guidelines for allowable supports and services including *personal needs, personal health, relationships, emotional health, job or volunteer work, transportation, adaptive equipment and supplies, and skilled supports* are listed below and are intended to broadly describe each category.

The Department of Health and Welfare encourages a participant's ability to completely customize their Support and Spending Plan. This includes designing and purchasing supports that are unique to the participant.

The following supports and services are allowed for:

Personal Needs

- Help with daily living activities such as shopping for food, meal planning and preparation, housekeeping, bathing, dressing, and personal hygiene.
- Training and/or help handling personal finances, making purchases, and meeting personal financial obligations.
- Home Modifications required in a participant's residence which allow the participant to remain safely in the community and/or function with greater independence. Home modifications should comply with the following requirements:
    - A minor home modification must not create a new structure, add square footage to the home, be for the purpose of remodeling, require routine maintenance, or be for

general utility or renovation (i.e. carpeting, roof repair, a carbon monoxide detector, central air conditioning, etc.).

- Permanent modifications are limited to a principal residence owned either by the participant or the participant's non-paid family member(s) if the participant is residing with the non-paid family member(s).
- Portable or non-stationary modifications may be made to rental units when such modifications can follow the participant to the next place of residency.
- Minor home modifications include installation, maintenance, and repair not covered by warranty.
- Purchase or repair of wheelchair ramps and protective awnings over wheelchair ramps.
- Modifications/additions to bathroom facilities:
  - Wheelchair accessible showers.
  - Sink modifications.
  - Bathtub modifications.
  - Toilet modifications.
  - Water faucet controls.
  - Floor urinal and bidet adaptations.
  - Plumbing modifications/additions to existing fixtures.
  - Turnaround space modifications.
- Modifications/additions to kitchen facilities:
  - Sink modifications.
  - Sink cut-outs.
  - Turnaround space modifications.
  - Water faucet controls.
  - Plumbing modifications/additions.
  - Work table/work surface adjustments/additions.
  - Cabinet adjustments/additions.
- Specialized accessibility/safety adaptations/additions (including repair and maintenance):
  - Door widening.
  - Electrical wiring.
  - Grab bars and handrails.
  - Automatic door openers/doorbells/door scopes and adaptive wall switches.
  - Fire safety adaptations and alarms.
  - Medically necessary air filtering devices.
  - Light alarms, doorbells for the hearing and visually impaired.
  - Floor leveling, only when the installation of a ramp is not possible.
  - Medically necessary steam cleaning of walls, carpet, support equipment, and upholstery.
  - Widening/enlargement of garage or carport to accommodate primary transportation vehicle and to allow participant using wheelchairs to enter and exit their vehicles.
  - Installation of sidewalk for access from non-connected garage or driveway to residence, when existing surface conditions is a safety hazard for the participant with a disability.

- Safety glass, safety alarms, security door locks, fire safety approved window locks and security window screens (i.e. for participants with severe behavioral problems).
- Security fencing for those participants with cognitive impairment and whose safety would be compromised if they wandered.
- Protective padding and corner guards for walls for participants with impaired vision and mobility.
- Recessed lighting with mesh covering and metal dome light covers to compensate for violent aggressive behavior (i.e. for participants with autism or mental illness).
- Noise abatement renovations to provide increased sound proofing (i.e. for participants with autism or mental illness).
- Door replacement (for accessibility only).
- Motion sensory lighting.
- Intercom systems for participants with impaired mobility.
- Lever door handles.

NOTE: Installation of central air conditioning and heating is excluded. Repair of central air conditioning and heating units will be considered only if it is more cost-effective than options available under adaptive aids.

Personal Health

- Drug/Alcohol rehabilitation services.
- Smoking cessation classes.
- Assistance with medications, including filling a medi-set.
- Services intended to make the community care system more effective by helping participants gain access to medical, social, educational, and other services, regardless of how each service is funded. When a participant's care is coordinated, it allows those participants who have complex personal circumstances that place them at risk of reduced independence to locate the appropriate services, and helps them coordinate those services.
- Nursing services which consist of part-time or intermittent care provided by a licensed nurse within the scope of the Idaho Nurse Practice Act. Nursing services may only be approved for those participants in need of services that can only be provided by an LPN (Licensed Practical Nurse) or RN (Registered Nurse).
- Fees or membership dues for health clubs or fitness centers when physical exercise or physical activity is necessary and appropriate to maintain or improve the participant's health and functioning. If authorized, the payment structure shall be based on the most cost effective option (i.e. daily rates, annual memberships, etc.) given the participant's actual and projected use of the health club or fitness center. Individuals must periodically provide verification of their use of the health club or fitness center.
- Medical Supplies which are medically necessary to meet the needs of the participant. The supplies must be related to the participant's disability or medical condition and must support the participant living in the most integrated setting possible in the community. These include supplies for:
  - Tracheotomy care.
  - Decubitus care.

- Ostomy care.
- Respirator/ventilator care.
- Catheterization.

Other Types of Medical Supplies

- Nutritional supplements.
- Feeding formulas and supplies.
- Urinary incontinent supplies.

Emotional Health

- Membership fees associated with attending support groups (i.e. Alcoholics Anonymous).
- Coursework and training material fees associated with participation in classes to acquire socially appropriate behaviors or reduce inappropriate behaviors (i.e. Anger Management course).

Relationship Needs

- Services that allow a participant to be involved in general community activities and establish relationships with family and peers.
- Services intended to instruct the participant in daily living and community living skills in integrated settings (i.e. shopping, church attendance, sports, participation in clubs, etc.).
- Behavior shaping and management services that include training and/or assistance in appropriate expressions of emotions or desires, compliance, assertiveness, acquiring socially appropriate behaviors, or reducing inappropriate behaviors.
- Development of interpersonal relationship skills of interaction, cooperation, trust, and the development of self-respect, self-esteem, responsibility, confidence, and assertiveness.
- Sex education services.
- Pregnancy counseling.

Job or Volunteer Work

- Individualized assessment.
- Individualized and group employment counseling.
- Individualized job development and placement that produce an appropriate job match for the participant and the employer.
- On the job training in work and related work skills required for job performance.
- Ongoing supervision and monitoring of the participant's performance.
- Ongoing support services to ensure job retention.
- Training in related skills essential to obtaining and retaining employment.
- Job maintenance visits with the employer for purposes of obtaining, maintaining, and/or retaining current or new employment opportunities.
- Services that assist a participant to develop and operate their own business. This assistance consists of:
  - Helping the participant identify potential business opportunities.

- Help developing a business plan, including potential sources of business financing, and help developing and launching the business.
- Identifying the supports that are necessary for the participant to operate the business.
- Ongoing help, counseling, and guidance once the business has been launched.

Payment for Job or Volunteer Work Excludes

- Incentive payments made to an employer to encourage or subsidize an employer's desire to retain a participant as an employee.
- Payments that are passed through to the participant.
- Payments for training that is not directly related to the participant's employment.
- The trainer or supervisor doing the work for the person, if the participant is not able to perform the essential functions of the job on their own.

Transportation

- Services that allow the participant to access community activities in response to needs identified through the participant's plan of care. These services are available to participants living in their own homes or in their family home. Transportation services may be provided by different modalities, including public transportation, taxi services, and non-traditional transportation providers. Transportation services must be provided by the most cost efficient mode available.
- Training or assistance aimed at accessing and using public transportation, independent travel, or movement within the community.

Adaptive Equipment and Supplies

- Specialized equipment and supplies such as devices, controls, or appliances which enable participants to increase their ability to perform activities of daily living, or to perceive, control, or communicate with their environment. They also include items necessary for life support including ancillary supplies and equipment necessary to maintain such items, and durable and non-durable medical equipment and supplies. Training on the proper use of the equipment is to be included in the unit cost of the equipment and normal fitting, and maintenance of equipment, where necessary. All items will meet applicable standards of manufacture, design, and installation.
- All specialized medical equipment and supplies must be prescribed by a medical practitioner.
- Specialized medical equipment and supplies costing more than $500 require written documentation from an occupational, physical, or speech therapist, or speech pathologist that the purchase is appropriate to meet the participant's needs.
- Reimbursement for repair, modification, or adaptation of specialized equipment and supplies, if determined to be cost effective.
- Adaptive aids consist of the following services including repair and maintenance not covered by the warranty.

Lifts

- Wheelchair lifts.
- Porch or stair lifts.

- Hydraulic, manual, or other electronic lifts.
- Stairway lifts.
- Bathtub seat lifts.
- Ceiling lifts with tracks.
- Transfer bench.

Mobility Aids
- Manual/electric wheelchairs and necessary accessories.
- Scooters.
- Mobility bases for customized chairs.
- Braces, crutches, walkers, and canes.
- Forearm platform attachments for walkers and motorized/electric wheelchairs.
- Prescribed prosthetic devices.
- Prescribed orthotic devices, orthopedic shoes, and other prescribed footwear.
- Prescribed exercise equipment and therapy aids.
- Portable ramps.
- Batteries and chargers.

Respiratory Aids
- Ventilators/respirators.
- Back-up generators.

Positioning Devices
- Standing boards, frames, and customized seating systems.
- Electric or manual hospital beds, tilt frame beds, and necessary accessories.
- Egg crate mattresses, sheepskin, and other medically related padding.
- Trapeze bars.
- Lift recliners.

Communication Aids (Including Repair, Maintenance, and Batteries)

Augmentative Communication Devices
- Direct selection communicators.
- Alphanumeric communicators.
- Scanning communicators.
- Encoding communicators.
- Speaker and cordless phones for participants who cannot use conventional telephones:
  - Speech amplifiers, aids, and assistive devices.
  - Interpreters.
  - Telebraille devices.
  - Typewriters.
  - Closed captioning devices.

Control Switches/Pneumatic Switches and Devices

- Sip and puff controls.
- Adaptive switches/devices.

Environmental Control Units

- Locks.
- Electronic devices.
- Voice activated, light activated, oral motion activated device.
- Alarms/alarm systems.

Diagnostic/Monitoring Equipment Such As

- Stethoscopes, blood pressure monitors, and thermometers for home use.
- Blood glucose monitors.

Medically Necessary Devices Such As

- Urinary incontinent devices.
- Transcutaneous Electrical Nerve Stimulation (TENS) units.

Medically necessary Durable Medical Equipment not covered in the State Plan for the Idaho Medicaid Program.

Temporary lease/rental of medically necessary durable medical equipment to allow for repair, purchase, replacement of essential equipment or temporary usage of the equipment.

Modifications/Additions to Primary Transportation Vehicles

- Van lifts.
- Driving controls.
    - Brake/accelerator hand controls.
    - Dimmer relays/switches.
    - Horn buttons.
    - Wrist supports.
    - Hand extensions.
    - Left-foot gas pedals.
    - Right turn levers.
    - Gear shift levers.
    - Steering spinners.
- Medically necessary air conditioning unit prescribed by a physician for participants with respirator or cardiac problems, or people who can't regulate temperature.
- Removal or placement of seats to accommodate a wheelchair.
- Installation, adjustment, or placement of mirrors to overcome visual obstruction of a wheelchair in a vehicle.
- Raising the roof of the vehicle to accommodate a participant riding in a wheelchair.
- Installation of frames, carriers, or lifts for transporting mobility aids.

Sensory Adaptations

- Eyeglasses and accessories beyond the Medicaid limit.

- Hearing aid supplies beyond the Medicaid limit.
- Auditory adaptations to mobility devices.
- Medically necessary heating and cooling equipment for participants with respiratory or cardiac problems, people who cannot regulate temperature, or people who have conditions affected by temperature (excluding central air conditioning and heating). An air conditioner can only be purchased for the participant's principal living area. If the principal living area already has an air conditioner unit, it would not be possible to purchase another unit to cool another part of the house.
- Visual alert systems.
- Magnifiers.
- Enlarged electronic displays.

Adaptive Equipment for Activities of Daily Living

- Assistive devices.
- Reachers.
- Stabilizing devices.
- Weighted equipment.
- Holders.
- Feeding devices including:
  - Electric self-feeders.
  - Food processor and blender. Only for participants with muscular weakness in upper body or who lack manual dexterity and are unable to use manual conventional kitchen appliances.
  - Variations of everyday utensils.
  - Shaped, bent, built-up utensils.
  - Long-handled equipment.
  - Addition of friction covering.
  - Coated feeding equipment.
- Count-a-dose medication systems.
- Walking belts and physical fitness aids.
- Specially adapted kitchen appliances.
- Toilet seat reducer rings.
- Hand-held shower sprays.
- Shower chairs.
- Electric razors.
- Electric toothbrushes.
- Water piks.
- Over bed tray tables.
- Signature stamps.
- Care and acquisition of guide dogs for visually impaired, including:
  - Veterinary bills.
  - Harnesses.
  - Food for guide dog.
  - Safety restraints and safety devices.
- Bed rails.

- Safety padding.
- Helmets.
- Safety restraints.
- Flutter boards.
- Lifejackets.
- Elbow and knee pads.
- Visual alert systems.
- Support rails.

Skilled Supports

- Developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services). Physical and occupational therapy and recreation (including arts and therapeutic recreation). Social work services and counseling services (including rehabilitation counseling). Medical services (except for diagnosis and evaluation purposes only).

Unallowable Expenditures

Supports and services that cannot be purchased within the participant's budget are:

- Placement in a nursing home (NH) or Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR).
- State Plan services (i.e. Service Coordination and Developmental Disability Agency services).
- Waiver services delivered through the traditional service model.
- Services, goods, or supports provided to or benefiting persons other than the participant.
- Any costs for service incurred by the participant such as attorney fees, bank overdraft fees, etc.
- Insurance payments.
- Room and board payments.
- Personal items not related to the participant's disability.
- Home modifications that add any square footage.
- Home modifications for a residence other than the primary residence of the participant or the participant's non-paid family member(s) if the participant is residing with the non-paid family member(s).
- Expenses for travel, lodging, or meals related to training the participant or his/her representative or paid or unpaid caregivers.
- Experimental treatments.
- Membership costs or dues, unless the service or support obtained through membership is directly related to the disability.
- Vacation expenses other than the cost of direct services.
- Vehicle maintenance does not include maintenance to modifications related to the disability.
- Tickets and related costs to attend sporting or other recreational events.
- Animals and their related costs, except for guide dogs for the visually impaired.
- Costs related to internet access.

APPENDIX B

Medicaid Rate Chart

DEVELOPMENTAL DISIBILITIES (DD) AND IDAHO STATE SCHOOL AND HOSPITAL (ISSH) WAIVER SERVICES	PROCEDURE CODE & MODIFIER(S)	MEDICAID REIMBURSEMENT RATE
1. RESIDENTIAL HABILITATION: Supported Living		
A. Individual supported living services: Participant or group living arrangement (1 to 3 participants).	**H2015-U8**	$12.96/Hr.; 1 Unit = 15 Minutes; 1 Unit = $3.24. (24 hours/day unavailable under hourly services.)
B. Group supported living services: Group living arrangement (2 or 3 participants).	**H2015-U8 HQ**	$7.64/Hr.; 1 Unit = 15 Minutes; 1 Unit = $1.91. (24 hours/day unavailable under hourly services.)
C. Daily supported living services:		
a. *High Support:* Participants must meet the SIB-R Support levels of Pervasive, Extensive, or Frequent.	**H2022**	Blended staff: $225.32/Day; 1 Unit = 1 Day. (24 Hours/Day supported living service.)
b. *Intense Support:* Participants require intense one-on-one supports. Evaluation is case-by-case using the intense support criteria.	**H2016-U8**	1:1 Staff: $268.36/Day; 1 Unit = 1 Day; Requires prior authorization. (24 Hours/Day supported living service.)
c. *School Based Services High Support:* School days. Non-school days.	**H2016** **H2022**	Blended staff: $178.33/Day; 1 Unit = 1 Day; Requires prior authorization. Blended staff: $225.32/Day; 1 Unit = 1 Day; Requires prior authorization.
d. *School Based Services Intense Support:* School days. Non-school days.	**H2016** **H2016**	1:1 Staff: $212.46/Day; 1 Unit = 1 Day; Requires prior authorization. 1:1 Staff: $268.36/Day; 1 Unit = 1 Day; Requires prior authorization.

2. RESIDENTIAL HABILITATION AGENCY AFFILIATION FOR CERTIFIED FAMILY HOME (CHF).		
A. Agency affiliated with a single CFH with 1 to 4 participants.	**0919B**	$7.96/Day; 1 Unit = 1 Day, for each participant.
B. CFH provider affiliated with a Residential Habilitation Agency. The rate paid to the CFH provider for each participant living in the CFH.	**S5140-U8**	$53.39/Day; 1 Unit = 1 Day, for each participant.
3. CHORE SERVICES: Skilled.	**S5121-U8**	Lowest of (3) three competitive bids. PAC 5 – manually priced.
4. RESPITE CARE:	**T1005-U8** **S9125-U8**	$8.48/Hr.; Limited to 6 hours or 24 units a day; 1 Unit = 15 Minutes; 1 Unit = $2.12 for each Unit. $53.39/Day maximum.
5. SUPPORTED EMPLOYMENT: Limited to 40 hrs a week maximum in combination with Developmental and Occupational Therapy, IBI, or Adult Day Care.	**H2023-U8**	$21.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $5.25. 160 units a week maximum.
6. NON-MEDICAL TRANSPORTATION:	**A0080-U8**	$.44/mile, for each person provided by an agency. $.10/mile, for each vehicle provided by a participant. Limited to 1,800 miles for each individual support plan year.
7. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS:	**S5165-U8**	Actual cost or lowest of (3) three competitive bids for items over $500.00 (including labor).
8. SPECIALIZED MEDICAL EQUIPMENT Ramps, environmental control such as switches to open doors and wheelchair lifts.	**E1399-U8**	75% of vendor's retail price.
9. PERSONAL EMERGENCY RESPONSE SYSTEM:	**S5160-U8** **S5161-U8**	Installation. One time, for each consumer, for each residence. Includes first month of service fee. Approximately $34.35/Month.
10. HOME DELIVERED MEALS:	**S5170-U8**	$5.23/Meal; Limited to 2 meals a day (14 meals a week).

11. NURSING SERVICES: Nursing Oversight – Assessment/evaluation, training, and supervision of nursing services provided by Residential Habilitation or other Medicaid providers. Skilled Nursing Services – Services that require technical or professional licensed personnel.	**T1001-U8 TD** **T1001-U8 TD** **T1001-U8** **T1000-U8** **T1000-U8 TE** **T1000-U8 TD**	**Nursing Oversight:** Independent RN: $35.59/Visit. Agency RN: $44/49/Visit. RN oversight of LPN visits: $35.59/Visit. **Skilled Nursing Services:** Independent RN: $24.48/Hr.; 1 Unit = 15 Minutes; 1 Unit = $6.12. Agency LPN: $20.80/Hr.; 1 Unit = 15 Minutes; 1 Unit = $5.20. Agency RN; $30.60/Hr.; 1 Unit = 15 Minutes; 1 Unit =$7.65.
12. BEHAVIOR CONSULTATION / CRISIS MANAGEMENT:	**H2019-U8-U1** **H2019-U8** **H2019-U8 HM**	Psychiatric Consultation Psychiatrist: $40.08/Hr.; 1 Unit = 15 Minutes; 1 Unit = $10.02. QMRP/Clinician: $25.68/Hr.; 1 Unit = 15 Minutes; 1 Unit = $6.42. Behavioral Consultation Emergency Intervention Tech: $11.60/Hr.; 1 Unit = 15 Minutes; 1 Unit = $2.90. Limited to 96 units a month.
13. ADULT DAY CARE: Limited to 30 hours a week as a single service or 30 hours a week maximum in combination with Developmental and Occupational Therapy.	**S5100-U8**	$6.00/Hr.; 1 unit = 15 minutes; 1 unit = $1.50. 30/Hrs. a week maximum.
STATE PLAN SERVICES	**NEW PROCEDURE CODE**	**MEDICAID REIMBURSEMENT RATE**
1. MEDICAL REPORT BASED ON EXAM WITH THE PARTICIPANT:	**99450**	$45.13 for each report.
2. MEDICAL REPORT BASED ON PAST RECORD:	**99080**	$10.38 for each report (effective 7/1/04).
3. PLAN DEVELOPMENT:	**G9007**	1 Unit = 15 Minutes; 1 Unit = $10.00. Limited to 12 hours a year.

4. PLAN MONITORING:	**G9012**	1 Unit = 15 Minutes; 1 Unit = $10.00. Limited to 8 hours a year.
5. TSC ONGOING: A. First Six Months. B. After Six Months.	 **G9001** **G9002**	 $129.81/Month for the first six months. $108.33/Month after six months.
6. DEVELOPMENTAL THERAPY: Limited to 30 hours a week as a single service or in combination with Occupational Therapy, Intensive Behavioral Intervention, Physical Therapy, Speech Therapy, and Psychotherapy.	**H 2032** **H2032 HQ** **97537** **97537 HQ** **H2000**	Center participant: $18.12/Hr.; 1 Unit = 15 Minutes; 1 Unit = $4.53. Center Group: $7.20/Hr.; 1 Unit = 15 Minutes; 1 Unit = $1.80. Home/Community participant: $20.04/Hr.; 1 Unit = 15 Minutes; 1 Unit = $5.01. Home/Community Group: $8.56/Hr.; 1 Unit = 15 Minutes; 1 Unit = $2.14. Evaluation: $18.12/Hr.; 1 Unit = 15 Minutes; 1 Unit = $4.53.
7. PHYSICAL THERAPY: Provided by Developmental Disabilities Agency (DDA): Limitations: More than 25 visits for each calendar year requires prior authorization from Medicaid staff. (Counts toward the 30 hour a week limitation on DDA therapy services.)	**97110** **97150 HQ** **97001**	Participant: $56.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.00. Group: $14.36/Hr.; 1 Unit = 15 Minutes; 1 Unit = $3.59. Evaluation: $56.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.00.
8. SPEECH THERAPY: Provided by a Developmental Disabilities Agency (DDA): Limited to 250 visits maximum for each calendar year. (Counts toward the 30 hour a week limitation on DDA therapy services.) Speech and Hearing evaluation combined.	**92507** **92508** **92506**	Participant: $56.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.00. Group: $17.48/Hr.; 1 Unit = 15 Minutes; 1 Unit = $4.37. Evaluation: $56.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.00.
9. OCCUPATIONAL THERAPY: Limited to 30 hours a week as a single service or in combination with Developmental Therapy, Intensive Behavioral Intervention, Physical Therapy, Speech Therapy, and Psychotherapy.	**97535** **97535 HQ** **97003**	Individual: $56.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.00. Group: $14.36/Hr.; 1 Unit = 15 Minutes; 1 Unit = $3.59. Evaluation: $56.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.00.

10. PSYCHOTHERAPY in a Developmental Disabilities Agency (DDA): Limitation: 45 hours a year, alone or in combination with Supportive Counseling. (Counts toward the 30 hour a week limitation on DDA therapy services). A. Individual Medical Psychotherapy. B. Group Medical Psychotherapy. C. Family Medical Psychotherapy. D. Psychiatric Diagnostic Interview and Exam. E. Psychological testing for diagnosis and evaluation.	**H0004** **90853** **90847** **90801** **96101** **96102** **96103**	Individual: $57.40/Hr.; 1 Unit = 15 Minutes; 1 Unit = $14.35. Group: $15.56/Hr.; 1 Unit = 15 Minutes; 1 Unit = $3.89. Family: $51.36/Hr.; 1 Unit = 15 Minutes; 1 Unit = $12.84. Evaluation: $65.84/Hr.; 1 Unit = 15 Minutes; 1 Unit = $16.46. Administered by a licensed psychologist or physician: 1 Unit = 1 Hour; 1 Unit = $59.32. Administered by a technician (see IR- MA06-10 dated 4/7/06 for complete definition): 1 Unit = 1 Hour $41.70. Administered by a computer, with professional interpretation and report: $25.99 for each assessment report.
10. SUPPORTIVE COUNSELING in a Developmental Disabilities Agency (DDA): Limitation: 45 hours a year, alone or in combination with Psychotherapy. (Count toward the 30 hour a week limitation on DDA therapy services.)	**H0004 HM**	$32.00/Hr.; 1 Unit = 15 Minutes; 1 Unit = $8.00.
12. PHARMACOLOGICAL MANAGEMENT: Including prescription use and review of medication with no more than minimal Psychotherapy.	**90862**	1 Unit = 1 Visit; 1 Unit $50.26.
13. SOCIAL HISTORY:	**T1028**	$39.76/Hr.; 1 Unit = 15 Minutes; 1 Unit = $9.94.
14. COLLATERAL CONTACT:	**90887**	$39.76/Hr.; 1 Unit = 15 Minutes; 1 Unit = $9.94.
15. MEDICAL TRANSPORTATION:	**S0215** **S0215 TF**	Agency: $.44/mile; (21 Miles or more requires Medical Transportation Unit PA). Individual: $.10; (Prior authorized if over 400 Miles).

16. INTERPRETATION; DEAF OR FOREIGN LANGUAGE: (Payment for foreign language and signing).	**8296A**	$12.16/Hr.; 1 Unit = 1 Hour.
17. COMMUNITY CRISIS SERVICES: Limited to a maximum of 20 hours for each crisis for a period of 5 consecutive days.	**H2011**	Crisis Intervention Service: 1 Unit = 15 Minutes; 1 Unit = $11.35.
18. MENTAL HEALTH SERVICE:		
A. Interactive Medical Psychiatric Diagnostic interview.	**90801**	1 Unit = 15 Minutes; 1 Unit = $37.04 MD with U1 modifier; 1 Unit = $16.46 for each unit.
	96101	Administered by a licensed psychologist or physician: 1 Unit = 1 Hour; 1 Unit = $59.32.
B. Psychological testing for diagnosis and evaluation.	**96102**	Administered by a technician; (see IR- MA06-10 dated 4/7/06 for complete definition). 1 Unit = 1 Hour $41.70.
	96103	Administered by a computer, with professional interpretation and report: $25.99 for each assessment report.
	90804	20-30 Minutes = $62.92 MD w/UA mod; $38.37 other. 40-50 Minutes = $94.41 MD w/UA mod; $57.57 other. 75-80 Minutes = $140.81 MD w/UA mod; $85.86 other.
C. Individual Psychotherapy.	**90806** **90808**	1 Unit = 15 Minutes; 1 unit = $8.44 MD w/U1 Mod. 1 Unit = $3.89 other.
D. Group Psychotherapy.	**90853**	1 Unit = $3.89 (N.F.).
E. Partial Care: Skills training and development.	**90853 -U4** **H2014**	1 Unit = 15 Minutes; 1 Unit = $2.44.
F. Pharmacologic Management: Including prescription, use, and review of medication with no more than minimal psychotherapy.	**90862**	1 Unit = 1 Visit; 1 Unit = $50.26/Visit.

G. Individual Psychosocial Rehabilitation.	**H2017**	1 Unit = 15 Minute; 1 Unit = $11.35.
H. Group Psychosocial Rehabilitation.	**H2014 HQ (Modifier Required)**	1Unit = 15 Minutes; 1 Unit = $2.77.

APPENDIX C

Employment Agreements

Employment agreements are developed for each community support worker and support broker hired by a participant.

A new employment agreement must be made when changes are made to a community support worker's or support broker's wage, job duties or category of service.

All employment agreements must be filled out completely and signed to be valid.

This Appendix includes the following:

1. Medicaid – Community Support Worker Agreement

2. Medicaid – Support Broker Agreement.

3. Participant – Community Support Worker Employment Agreement.

4. Criminal History Check; Waiver of Liability - Assumption of Risk.

5. Criminal History Check; Waiver of Liability - Assumption of Risk - Failed Criminal History Check.

6. Participant – Support Broker Employment Agreement.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Medicaid – Community Support Worker Agreement

This agreement is hereby made between the Self-Directed Community Supports Option, a Medicaid Option administered by the Department of Health and Welfare (the Department), and _____ a Community Support Worker.

This Community Support Worker is associated with an Agency. ☐ Yes ☐ No.

The Community Support Worker acknowledges that even though he/she is the employee of a participant in the Self-Directed Community Supports Option, the Department, through the Fiscal Employer Agent, is the source of payment for the Community Support Worker's wages for services performed under the Self-Directed Community Supports Option. Because of the unique relationships of the participant, the Department, and the Fiscal Employer Agent, the Community Support Worker acknowledges and agrees to the following:

1. Services provided to any participant under the Self-Directed Community Supports Option will be provided in compliance with the rules contained in the Idaho Administrative Procedures Act (IDAPA) 16.03.13, "Consumer-Directed Services."

2. Payment will not be requested through the Fiscal Employer Agent or the Department for any service not performed in accordance with the Self-Directed Community Supports rules, the employment agreement with the participant, or the participant's Support and Spending Plan. It is understood that neither the Fiscal Employer Agent nor the Department is liable to pay for any service performed that is not in conformance with the Self-Directed Community Support rules, the employment agreement, the participant, or the participant's Support and Spending Plan.

3. The Community Support Worker acknowledges that even though he/she is the employee of the participant, they are also a Medicaid provider under the Self-Directed Community Supports Option. As a provider the Community Support Worker agrees to accept payment received by the Fiscal Employer Agent as payment in full for services rendered under the Self-Directed Community Supports Option.

4. The Community Support Worker acknowledges they are an employee of the participant and not an employee of the Department or the Fiscal Employer Agent, and agrees that the Community Support Worker is not entitled to, nor will make claim for any employee benefits from the Department or the Fiscal Employer Agent, including but not limited to, worker's compensation, disability, life, and/or health insurance.

5. To protect the confidentiality of personal and health information relating to the participant and their participation in the Medicaid Self-Directed Community Supports Option, and to release that information only at the request of the participant or as otherwise allowed by law.

I have read the foregoing agreement, I understand it, and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms or conditions of this agreement or the rules may result in termination of this Agreement, and thereby the source of payment for my employment to any Self-Directed Community Supports participant.

_____

Printed Name of Community Support Worker

_____

Signature of Community Support Worker Date

Note: Each Community Support Worker must sign.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Medicaid – Support Broker Agreement

This agreement is hereby made between the Self-Directed Community Supports Option, a Medicaid Option administered by the Department of Health and Welfare (the Department), and _____, a Support Broker.

The Support Broker acknowledges that even though he/she is the employee of a participant in the Self-Directed Community Supports Option, the Department, through the Fiscal Employer Agent, is the source of payment for the Support Broker's wages for services performed under the Self-Directed Community Supports Option. Because of the unique relationships of the participant, the Department, and the Fiscal Employer Agent, the Support Broker acknowledges and agrees to the following:

1. That the Support Broker is a provider under the Idaho Medicaid Self-Directed Community Supports Option.
2. To promptly notify the Fiscal Employer Agent of any change of address or other Support Broker contact information.
3. To accept, as payment in full for all Self-Directed Community Supports services, payments made by the Fiscal Employer Agent, and will make no additional charge except as allowed by the Medicaid Self-Directed Community Supports Option.
4. To provide all Support Broker services according to the Participant-Support Broker Employment Agreement and all duties and responsibilities in accordance with the rules pertaining to the Support Broker contained in the Idaho Administrative Procedures Act (IDAPA) 16.03.13, "Consumer-Directed Services."
5. To protect the confidentiality of personal and health information relating to the participant and his participation in the Medicaid Self-Directed Community Supports Option, and to release that information only at the request of the participant or as otherwise allowed by law.
6. The Support Broker acknowledges that they are an employee of the participant and not an employee of the Department or the Fiscal Employer Agent, and agrees that the Support Broker is not entitled to, nor will make claim for, any employee benefits from the Department or the Fiscal Employer Agent, including worker's compensation, disability, life, and/or health insurance.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with all parties consenting by their signature.

_____

Support Broker Date

Participant – Community Support Worker Employment Agreement

This agreement is hereby made between_____, a Participant of the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and_____, a Community Support Worker (CSW).

The Participant desires to engage CSW for services under the SDCS Option. In exchange, the CSW desires to be paid for services provided to the Participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on time sheets submitted by the CSW and approved by the Participant.

To these mutual purposes, the parties promise and agree as follows:

1. CSW services are to be provided in accordance with the Participant's SDCS Support and Spending Plan, and the SDCS rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.

3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the SDCS Option or the Fiscal/Employer Agent, and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the Fiscal Employer Agent, including but not limited to, worker's compensation, disability, life or health insurance.

6. The CSW agrees to notify the Participant immediately in the event he/she is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.
7. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.

8. The CSW agrees to provide services in a safe, courteous and professional manner. The CSW acknowledges that any physical, sexual or mental abuse or neglect of the Participant by the CSW will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

9. The CSW agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.

10. The CSW understands and agrees that they cannot provide or bill for services until:

- an authorized Support and Spending Plan has been submitted to the FEA,
- the signed Employment Agreement has been submitted to the FEA
- the signed Medicaid-CSW Agreement has been submitted to the FEA, and
- the CSW has received their **ACUMEN identification number to be used on their time card.**

11. The CSW understands and agrees that no payment for services will be made until both the CSW and the Participant have signed the appropriate time sheets, acknowledging their accuracy, and have submitted them to the FE/A.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the Self Direction Waiver option, the CSW will not receive payment for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

More than forty (40) hours per week of paid work are allowed only if the CSW meets the criteria for employees that are exempted from overtime pay and minimum wage requirements as per the Fair Labor Standards Act.

The participant must obtain and follow guidance from the Idaho Department of Labor and Commerce to determine if the CSW is exempt from these requirements. It is the responsibility of the participant to ensure that the CSW is exempt if the participant requires the CSW to work more than forty (40) hours per week.

The CSW will be paid only for the specific services authorized as per the Support and Spending Plan.

The signing of this Employment Agreement by the participant and the CSW signifies that the parties acknowledge that the criteria for exemption from overtime and minimum wage requirements will be met prior to scheduling work hours in excess of forty (40) hours per week or agreeing to wages less than minimum wage standards.

COLUMN A	B	C		D		E
Service needed	**Type of Support** ☑ only one box	Number of hours per year		Wage per hour		Annual Cost
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS		X		=	$ Sub-Total
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** / ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** / _____ **Fill in code** ☐ **Code for third rate of pay/hour** / _____ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** / _____ **Fill in code** ☐ **Code for third rate of pay/hour** / ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** / _____ **Fill in code** ☐ **Code for third rate of pay/hour** / _____ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** / _____ **Fill in code** ☐ **Code for third rate of pay/hour** / _____ **Fill in code**		x		=	$ Sub-Total
	Total Cost of Agreement:					$

14. The CSW must meet the following specific qualifications in order to provide the following services including attaching copy of certification/licensure, if applicable, as outlined in Subsections 120.05 and 150.01:

_____

_____

_____

_____

15. The Community Support Worker (CSW) agrees to take all actions necessary to become Participant's employee, and to maintain the employment relationship by submitting necessary documents to the FEA, including:

- Completion of W-4, I-9 and other IRS required forms;
- A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks";
- A copy of this agreement; and
- Time sheets approved by Participant recording hours worked.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause upon two weeks notice. This agreement may be terminated at any time by the Participant due to unsatisfactory CSW performance.

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

CSW Date

Unless the Criminal History Background Check is waived, the Community Support Worker has applied for a Criminal History Background Check through the Department of Health and Welfare. **The verification number for the Background Check is:_____ .**

The CSW gives permission to the fiscal employer agent, **ACUMEN**, to notify the Participant (Employer) of the results of the Criminal History Background Check.
_____ CSW Signature.

☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list.

Instructions for Employment Agreement Calculation:

- Column A: Write in ONE specific service per box:
  - Our example: The participant will be receiving the following services from the CSW: Rides to and from work; Personal assistance at home; Personal assistance in the community; Companionship services at night.
  - "Rides to and from work" is written in the first box under Column A.
- Column B: Check the ONE code that describes the Service listed in Column A. Use one code per box per service.
  - This code must match the code that is used on the Support and Spending Plan Budget.
  - Our example: Transportation Support (TSS) would match the service of "Rides to and from work."
  - TSS is checked in the first box under Column B.
- Column C: Calculate how many hours per year of the service listed in the corresponding Column A box that the participant expects to use.
  - Our example: The CSW will provide ten hours per week of transportation, to and from work, for the participant. The participant will take two weeks of vacation per year. The CSW will provide 500 hours of rides per year. (50 weeks x 10 hours/per week = 500 hours.) 500 hours is listed in the first box in Column C.
- Column D: Write the wage per hour the CSW will be paid for the service that is listed in the corresponding column A. The minimum wage in Idaho is $5.15 per hour.
  - Only write in the CSW's hourly wage. DO NOT include employer taxes or other costs!
  - Our example: The service, "Rides to and from work" is a Transportation Support (TSS). The CSW will provide this service 10 hours a week, fifty hours per year, for a total of 500 hours per year. The CSW will be paid $5.50 per hour for this service. The amount of $5.50 is put in the first box in Column D.
- Column E: Write in the total annual cost for the service that is listed in the corresponding Column A.
  - Our example: The CSW will provide 500 hours of transportation at the wage of $5.50 per hour. The total annual cost for this service = $2,750.00

CONTINUE TO ADD SERVICES, LISTING EACH SPECIFIC SERVICE IN ITS OWN BOX UNDER COLUMN A AND USING CORRESPONDING COLUMNS TO CALCULATE WAGE AND COST. PLEASE SEE ATTACHED EXAMPLE.

Continuing Instructions: For Participants who Employ Same CSW for Multiple Rates for Same Support Code:

- Column A: Write in ONE specific service per box.
  - Using our example, the participant receives personal assistance at home, personal assistance in the community and companionship services at night. Each service is listed in its own box under Column A. All of these services are considered to be Personal Support Services.
  - Our participant wants to pay different rates for the Personal Support Services, depending on when and where they occur. EACH service is listed in a separate box under Column A.
  - See Example.
- Column B: Check ONE support code that describes the service listed in the corresponding Column A.
  - Support codes that are for the same service at a different wage are shown as modified with a number.
  - Our example: Personal assistance (PSS) matches the service of "Personal assistance at home."
  - Personal assistance, second rate of pay (PS2) matches the service of "Personal assistance in the community."
  - Personal assistance, third rate of pay (PS3) matches the service of "Companionship services at night."
  - Each code can have no more than three digits.
- Columns C, D and E: Follow the same directions as above for calculating costs.

Instructions for Employment of CSW Who Works More Than forty Hours Per Week and is Exempt from Overtime Pay Requirements as Per the Fair Labor Standards Act

- The participant must call the Idaho Department of Labor and Commerce to make sure the CSW job duties are consistent with the definition of duties of workers who are exempt from overtime and minimum wage laws.
- If the participant has confirmed this with the Department, he can proceed to the next step.
- Our sample participant wants the same CSW to provide all his services. The work week is more than forty hours per week because the CSW will be spending three nights per week at the home of the participant, as a paid companion.
- Column A: Write in ONE specific service per box which meets the definition.
    - For example: Companionship services at night.
- Column B: This service matches the support code for Personal Support. Because it is paid at a different rate than the personal supports provided in the home (PSS) or in the community (PS2), it is coded as PS3.
- Column C: Calculate the number of hours per year.
    - In our example, the participant will use this CSW for three nights per week, eight hours per night for fifty weeks. (Remember: He is taking a two week vacation with his family and will not need the CSW for this time period.)
    - The CSW will provide companionship services for 1,200 hours per year. (Eight hours x three nights a week x 50 weeks.)
- Column D: Companionship services are exempt from the minimum wage law.
    - In our example, the participant will pay the CSW $3.00 per hour for companionship services.
- Column E: Total the annual cost:
    - In our example, the CSW will be paid a gross wage of $3,600.00 per year.

Sample Employment Agreement

COLUMN A	B	C		D		E
Service needed	**Type of Support** ☑ only one box	Number of hours per year		Wage per hour		Annual Cost
Rides to and from work	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☒ Transportation TSS ☐ Relationship RSS ☐ Learning LSS	500 10 hr/wk. x 50 wks.	x	$5.50	=	$2,750.00 Sub-Total
Personal assistance at home	☒ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** _____ **Fill in code**	500 10 hr/wk. x 50 wks.	x	$7.00	=	$3,500.00 Sub-Total
Personal assistance in the community	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☒ **Code for second rate of pay/hour** __**PS2**__ **Fill in code** ☐ **Code for third rate of pay/hour** _____ **Fill in code**	1,000 20 hr/wk. x 50 wks.	x	$8.00	= =	$8,000.00 Sub-Total
Companionship services at night	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** _____ **Fill in code** ☒ **Code for third rate of pay/hour** __**PS3**__ **Fill in code**	1,200 24 hr/wk x 50 wks.	x	$3.00	=	$3,600.00 Sub-Total
	Total Cost of Agreement:					$ 17,850.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: _____

MID #: _____ Date: _____

Waiver: I do not want (name of Community Support Worker) _____ to be subject to criminal history check requirements.

Relationship to the participant: _____

Description of service: _____

_____

Reason:_____

_____

I will make sure I am healthy and safe by: _____

_____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such as damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there are things such as personal injury, property loss, abuse, neglect, and exploitation that could happen in my life as a result of my choice, even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide not to make the provider of my Self-Directed services have a criminal history check. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____

Participant Date

_____

Legal guardian (If Applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this participant.

Comments:

_____

_____

_____

Support Broker Date

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk - Failed Criminal History Check

Participant Name: _____

MID #: _____ Date: _____

Waiver: I choose to hire (name of Community Support Worker)

_____

as my Community Support Worker. I understand that they have failed the criminal history check according to the requirements of the Idaho Administrative Procedures Act (IDAPA) 15.05.06, “Criminal History and Background Checks”.

Relationship to the participant: _____

Description of service: _____

_____

Reason: _____

_____

_____

I will make sure I am healthy and safe by: _____

_____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such as damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there are things such as personal injury, property loss, abuse, neglect, and exploitation that could happen in my life as a result of my choice, even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide to hire a provider of my Self-Directed services who has a criminal history that would be precluded from providing services in the Idaho Medicaid Program. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____

Participant Date

_____

Legal guardian (If Applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this participant.

Comments:

_____

_____

_____

_____

_____

_____

_____

Support Broker Date

IDAHO DEPARTMENT OF HEALTH & WELFARE

Participant – Support Broker Employment Agreement

This agreement is hereby made between _____, a participant of the Self-Directed Community Supports Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and

_____, a Support Broker.

The participant desires to engage the Support Broker for services under the Self-Directed Community Supports Option. In exchange, the Support Broker desires to be paid for services provided to the participant. Both parties understand and agree that payment is made through a Fiscal Employer Agent, using Medicaid monies and based on time sheets submitted by the Support Broker and approved by the Employer, who is the participant.

To these mutual purposes, the parties promise and agree to the following:

1. Support Broker services are to be provided in accordance with the Participant-Support Broker Agreement, and the Self-Directed Community Supports rules, according to the Idaho Administrative Procedures Act (IDAPA) 16.03.13, “Consumer-Directed Services.”

2. The Support Broker is hired to assist the participant, and assumes no responsibility for the participant’s conduct.

3. The parties mutually agree that the Support Broker is an employee of the participant and not an employee of the Self-Directed Community Supports Option or the Fiscal Employer Agent, and agree that the Support Broker is not entitled to, nor will make claim for any employee benefits from the Self-Directed Community Supports Option or the Fiscal Employer Agent, including but not limited to, worker’s compensation, disability, life, and/or health insurance.

4. The Support Broker agrees to take all actions necessary to become the participant’s employee, and to maintain the employment relationship by submitting necessary documents to the Fiscal Employer Agent, including:
   - Support Broker Letter of Approval by the Department.
   - Completion of W-4, I-9 and other IRS required forms.
   - A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Criminal History and Background Checks”.
   - A copy of this agreement.
   - Time sheets approved by participant with recorded hours worked.

5. The Support Broker agrees to provide all required Support Broker duties outlined in Subsection 136.02 of IDAPA 16.03.13, "Consumer-Directed Services", and as mutually agreed upon with the participant, the optional Support Broker duties outlined in Subsection 136.03 of IDAPA 16.03.13, "Consumer-Directed Services."

6. The Support Broker's wage will be $_____ per hour, (not to exceed $18.72 per hour). It is mutually understood that any overtime hours or services not described in the participant's Self-Directed Community Supports Support and Spending Plan, or described elsewhere in this Agreement, are not covered by or paid through this agreement.

7. Terms and conditions of work (Job Duties):

Service or task	How often task or service will be provided (i.e. Weekly, Monthly, Yearly)	Number of hours needed each month to perform task		How many months of the year this task will need to be performed		Annual Cost
Person Centered Planning participation includes:			**X**		**=**	$ Sub Total
Development of written Support and Spending Plan includes:			**X**		**=**	$ Sub Total
Helping the employer review and monitor budget includes:			**X**		**=**	$ Sub Total
Submit employer satisfaction documentation to department as requested, includes:			**X**		**=**	$ Sub Total
Participating in quality assurance process with Department includes:			**X**		**=**	$ Sub Total
Helping employer with annual re-determination process includes:			**X**		**=**	$ Sub Total
Helping employer meet participant responsibilities includes:			**X**		**=**	$ Sub Total
Other: Give details of job duties:			**X**		**=**	$
			X		**=**	$
			X		**=**	$
			X		**=**	$
Total Cost of Annual Support					**=**	**$** **TOTAL**

The Support Broker understands and agrees that they cannot provide or bill for services until:

- An authorized Support and Spending Plan has been submitted to the Fiscal Employer Agent.
- The signed Support Broker Employment Agreement has been submitted to the Fiscal Employer Agent.
- The signed Medicaid-Support Broker Agreement has been submitted to the Fiscal Employer Agent.
- The Support Broker has received their ACUMEN identification number to be used on their time sheet.

Medicaid funds only services rendered. Under the provisions of this agreement, the employee cannot bill for holiday, vacation, or sick time taken. Overtime hours are not allowed.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing by both parties consenting with their signatures. It is mutually understood that this is employment at will. Either party may terminate the relationship without cause upon thirty (30) days notice. This Agreement may be terminated immediately at any time by the participant due to unsatisfactory Support Broker performance.

Participant	Date
Legal Guardian (If Applicable)	Date
Support Broker	Date

Instructions for Hiring an Independent Contractor to Provide Services

Self direction participants who want to hire an independent contractor to provide services must follow this process:

1. Contact the independent contractor who participant wants to hire.

2. Explain the process of how the contractor will be paid:
   - The contractor will present an Invoice to Participant based on the Work Agreement;
   - Participant submits Invoice to the Fiscal Agent (Acumen);
   - Fiscal Agent (Acumen) sends Participant a check made out to the Contractor;
   - Participant gives check to Contractor.
   - Pay periods are twice per month, as per schedule published by Fiscal Agent.

3. Once the agency agrees to partner with participant, complete *Work Agreement.*
   - The *Work Agreement* must include total cost associated with the agreement.
   - As per the *Agreement*, the contractor must either complete a criminal history check or obtain a signed Waiver of the criminal history check from Participant.
   - The verification number of the criminal history check must be included on the *Work Agreement* or the signed Waiver must be provided.

4. *The Support and Spending Plan* must reflect the total cost of the *Work Agreement.*
   - *The Support and Spending Plan* must be authorized by the regional care manager.

5. Submit the *Participant – Contractor Work Agreement* to the Regional Care Manager.

6. The Regional Care Manager will ensure that the worker(s) is not listed on the Medicaid Exclusion (from Medicaid payment) list and that the Criminal History Background Check is complete or a Waiver is signed.

7. The contractor must provide participant and the agency with an Invoice detailing their work each pay period that they work.
   - Participant must validate the Invoice.

8. The participant submits the *Invoice* with a *Vendor Request for Payment* form to Acumen each pay period, using the pay period chart Acumen has provided.
   - The *Invoice* can include more than one code and more than one rate of pay.

9. Acumen sends a check made out to Contractor to the Participant for the amount specified on the Request for Vendor Payment.

10. Participant gives check to Contractor.

11. Additional terms regarding the *Work Agreement* can be negotiated and added to the Agreement in the space provided.

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Participant – Independent Contractor Work Agreement

This agreement is hereby made between_____, a Participant of the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department),

_____ , an independent contractor, hereafter referred to as 'Contractor.'

The Participant desires to engage Contractor to provide services under the SDCS Option. In exchange, Contractor will bill for services provided to the Participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on invoices submitted by Contractor and approved by the Participant. To these mutual purposes, the parties promise and agree as follows:

1. Contractor services are to be provided in accordance with the Participant's SDCS Option Support and Spending Plan, and the SDCS Option rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that Contractor is an independent worker and not the employee of the participant and as such, is responsible for filing tax information with the Internal Revenue Service.

3. Contractor will provide services as directed, controlled and approved by the participant.

4. Contractor is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

5. Contractor ensures that he/she meets the minimum qualifications to be a support worker, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

6. The parties mutually agree that Contractor is not an employee of the SDCS Option or the Fiscal/Employer Agent, and agree that Contractor is not entitled to nor will make claim for any employee benefits from the SDCS Option or the Fiscal Employer Agent, including but not limited to, worker's compensation, disability, life or health insurance.

7. Contractor agrees to notify the Participant immediately in the event the he/she is unable to provide the agreed services due to sickness, injury or personal emergency.

8. Contractor agrees to provide services in a safe, courteous and professional manner. Any physical, sexual or mental abuse or neglect of the Participant by the contractor will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

9. Contractor agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to Adult Protection Services authorities immediately.

10. Contractor understands and agrees that he/she cannot provide or bill for services until:

a.) An authorized Support and Spending Plan has been submitted to the FEA.
b.) Contractor has either cleared the criminal history background check or has had a Waiver signed by the Participant.

11. Contractor understands he/she will not be paid for services until:

a.) An invoice has been submitted to and signed by the participant.

b.) The invoice has been submitted to the FEA.

c.) The Participant's Support and Spending Plan authorizes the service that Contractor has completed.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the SDCS option, Medicaid will not reimburse Contractor for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an amount in excess of this agreement.

Contractor will provide the following service(s) to the Participant:

Service needed	**Type of Support** ☑ only one box	Frequency How often or how many hours:		Duration: How long a period of time will the service be offered:		Annual Cost
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS		X		=	$ Sub-Total
Service needed	**Type of Support** ☑ only one box					Annual Cost
	☐ Personal PSS / ☐ Emotional ESS ☐ Job JSS / ☐ Skilled Nursing SNS ☐ Transportation TSS / ☐ Relationship RSS ☐ Learning LSS		X		=	$ Sub-Total

Service needed	**Type of Support** ☑ only one box					Annual Cost
	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS ☐ Learning LSS ☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS		**X**		**=**	$ Sub-Total
	TOTAL COST OF AGREEMENT				**=**	$ TOTAL

Contractor must meet the following specific qualifications in order to provide the above services including attaching copy of certification/licensure, if applicable, as outlined in Subsections 120.05 and 150.01:

_____

_____

Additional terms of this agreement are as follows:

_____

_____

_____

_____

_____

Unless the Criminal History Background Check is waived, the Community Support Worker or Contractor has applied for a Criminal History Background Check through the Department of Health and Welfare. The verification number for the Background Check is: _____.

Contractor gives permission to the Department of Health and Welfare, Division of Medicaid, to notify the Participant (Employer) of the results of the Criminal History Background Check.

_____
Signature.

☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived Contractor cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause upon two weeks notice. This agreement may be terminated at any time by the Participant due to unsatisfactory worker or Contractor performance.

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

INDEPENDENT CONTACTOR Date

Instructions for Hiring an Agency to Provide Community Support

Self direction participants who want to hire an agency to provide community support workers must follow this process:

1. Contact the agency which employs the community support worker(s) who participant wants to hire.
- Request that the agency partners with participant so that participant can employ specific worker(s) from the agency.
- Explain to the agency that they are responsible for processing payroll, payroll taxes and reporting of income and taxes for the workers.
- Worker(s) remain employees of the agency.
- Present the agency or contractor with a copy of the *Participant – Agency/Community Support Worker Employment Agreement* for review. (See attached *Agreement.*)
- Explain that the agency is responsible for tasks as detailed in the *Employment Agreement.*

2. Once the agency agrees to partner with participant, complete *Employment Agreement.*
- The *Employment Agreement* must include total cost associated with the agreement.
- As per the *Agreement*, the community support worker(s) must either complete a criminal history check or obtain a signed Waiver of the criminal history check from participant.
- The verification number of the criminal history check must be included on the *Employment Agreement* or the signed Waiver must be provided.

3. *The Support and Spending Plan* must reflect the total cost of the *Employment Agreement.*
- *The Support and Spending Plan* must be authorized by the regional care manager.

4. Submit the *Participant – Agency/ Community Support Worker Employment Agreement* to the Regional Care Manager.

5. The Regional Care Manager will ensure that the worker(s) is not listed on the Medicaid Exclusion (from Medicaid payment) list and that the Criminal History Background Check is complete or a Waiver is signed.

6. The community support worker must provide participant and the agency with a time sheet detailing their work hours each pay period that they work.
- Participant must validate and sign the time sheet.
- The community support worker submits the time sheet to the agency.

7. The agency must provide participant with an *Invoice* each pay period which matches the time sheet.
- Participant must sign and date the *Invoice* for it to be valid.

8. The participant submits the *Invoice* with a *Vendor Request for Payment* form to Acumen each pay period, using the pay period chart Acumen has provided.
   - The *Invoice* can include information on more than one worker, as long as time sheets have been signed.
   - The *Invoice* can include different codes and different rates of pay per worker.

9. Acumen reimburses the agency the amount specified on the *Invoice*.

10. The agency pays the community support worker.

11. Additional terms regarding the *Employment Agreement* can be negotiated and added to the Agreement in the space provided.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Participant – Agency/Community Support Worker Employment Agreement

This agreement is hereby made between_____, a Participant of the Self Directed Community Supports (SDCS) Option, a Medicaid Option administered by the Department of Health and Welfare (Department), and _____, an agency.

It is mandatory to identify specific Community Support Worker(s) who will be supplying services under this agreement.

The names of the individual(s) who will provide Community Support services under this agreement are:

_____

_____

The Participant desires to engage the agency to provide Community Support Worker(s) (CSW) for services under the SDCS Option. In exchange, the agency will bill for and provide payment to the CSW for services provided to the Participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on time sheets submitted by the CSW and approved by the Participant.

The CSW will remain employee(s) of the agency and the agency agrees to provide services which might otherwise be the responsibility of the Participant, as detailed in the "Additional Terms" section. To these mutual purposes, the parties promise and agree as follows:

1. CSW services are to be provided in accordance with the Participant's SDCS Option Support and Spending Plan, and the SDCS Option rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."

2. It is mutually understood that the CSW remains the employee of the agency but will provide services as directed, controlled and approved by the participant.

3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

4. The agency will ensure that the CSW meets the minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, “Consumer-Directed Services.”

5. The parties mutually agree that CSW is an employee of the agency and is not an employee of the SDCS Option or the Fiscal/Employer Agent, and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the Fiscal Employer Agent, including but not limited to, worker’s compensation, disability, life or health insurance.

6. The agency agrees to notify the Participant immediately in the event the CSW is unable to provide the agreed services due to sickness, injury or personal emergency. The CSW must obtain the Participant's written approval in advance for any pre-planned absence.

7. Unless the Participant specifies otherwise in the “Additional Terms” section of this agreement, the agency shall train the CSW on the duties and responsibilities of the CSW.

8. The agency shall be responsible for ensuring the accuracy of CSW’s time records.

9. The agency agrees to train and require the CSW to provide services in a safe, courteous and professional manner. The agency acknowledges that any physical, sexual or mental abuse or neglect of the Participant by the CSW will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

10. The agency agrees to train and require the CSW to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.

11. The agency understands and agrees that they cannot provide or bill for services until:

a.) An authorized Support and Spending Plan has been submitted to the FEA.
b.) The Community Support Workers have either cleared the criminal history background check or have Waivers signed by the Participant.

12. The agency understands they will not be paid for services until:

a.) A time sheet has been submitted to and signed by the participant.

b.) An invoice which correlates to the CSW’s time sheet has been supplied by the agency and signed by the participant.

c.) The invoice has been submitted to the FEA.

13. It is mutually understood that Medicaid funding can only pay for services rendered. Under the SDCS option, Medicaid will not reimburse the agency or the CSW for any

vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

The agency will ensure that any CSW who performs paid work in excess of forty (40) hours per week or works for less than minimum wage has met the criteria for exemption from the requirements for overtime and minimum wage, as per the Fair Labor Standards Act and the Idaho Department of Commerce and Labor.

The Agency will provide the following services to the Participant:

COLUMN A	B	C		D		E
Service needed	**Type of Support** ☑ only one box	Number of hours per year		Wage per hour		Annual Cost
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** _____ **Fill in code** ☐ **Code for third rate of pay/hour** _____ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** _____ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		X		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** _____ **Fill in code** ☐ **Code for third rate of pay/hour** _____ **Fill in code**		x		=	$ Sub-Total

	☐ Personal PSS ☐ Job JSS ☐ Transportation TSS ☐ Learning LSS ☐ **Code for second rate of pay/hour** ☐ **Code for third rate of pay/hour**	☐ Emotional ESS ☐ Skilled Nursing SNS ☐ Relationship RSS _____ **Fill in code** _____ **Fill in code**		**x**		**=**	$ Sub-Total
	Total Cost of Agreement:						$

14. The CSW must meet the following specific qualifications in order to provide the above services including attaching copy of certification/licensure, if applicable, as outlined in Subsections 120.05 and 150.01:

_____

_____

_____

_____

15. Additional terms of this agreement are as follows:

_____

_____

_____

_____

Unless the Criminal History Background Check is waived, the Community Support Worker has applied for a Criminal History Background Check through the Department of Health and Welfare. **The verification number for the Background Check is: _____.**

The CSW gives permission to the Department of Health and Welfare, Division of Medicaid, to notify the Participant (Employer) of the results of the Criminal History Background Check.

_____
Signature.

☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list.

The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause upon two weeks notice. This agreement may be terminated at any time by the Participant due to unsatisfactory worker or Contractor performance.

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

AGENCY IF APPLICABLE Date

IDAHO DEPARTMENT OF
HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: _____**MID #** _____ **Date:** _____

Waiver: I do not want (name of community support worker) _____ to be subject to Criminal History Check requirements.

Relationship to the Participant:_____

Description of Service: _____

Reason: _____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide not to make the provider of my Self-Directed services have a Criminal History Check. I agree that my choice is voluntary and that I knowingly assume all such risks.

_____ _____

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments: _____

_____

Signature of Support Broker Date

IDAHO DEPARTMENT OF HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk – Failed Criminal History Check

Participant Name: _____**MID #** _____ **Date:** _____

Waiver: I choose to hire (name of community support worker) _____ as my community support worker. I understand that they have failed the criminal history check per requirements at IDAPA 15.05.06, "Rules Governing Mandatory Criminal History Checks".

Relationship to the Participant: _____

Description of Service: _____

Reason: _____

_____

_____

I Will Make Sure I am Healthy and Safe by: _____

_____

_____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my

_____ _____

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____ regarding the risks of waiving a criminal history check for this individual.

Comments:

_____

_____

Signature of Support Broker _____

APPENDIX D

Participant Experience Survey

Employer Name: _____ Date: _____

Support Broker Name: _____

Community Support Worker Name: _____

Quality Assurance Review Questions	Yes	No	N/A
1. Do you help pick the people who help you?			
2. Do you know you can change your support staff, if you want to?			
3. Do you tell your support staff what to help you with?			
4. Would you like to tell them the things you want help with?			
5. When you are with your support staff at home, can you eat when you want to?			
6. Can you watch TV when you want to?			
7. Can you go to bed when you want to?			
8. Did you choose the days and time the support worker provides services?			
9. Do the support staff who help you, respect you?			
10. Do they say “please” and “thank you” when they ask you to do something?			
11. Does the support staff listen carefully, to what you ask them to do?			
12. Does anyone take your things without asking first? 13. If yes, what happens? Would you like to tell someone about this? (Specify) 14. Who takes your things without asking first? (Specify)			
15. Does anyone ever do mean things to you, such as yell at you? 16. What happens? Would you like to tell someone about this? (Specify) 17. Who is mean to you or yells at you? (Specify)			

18. Does anyone ever hit you or hurt your body? 19. What happens? Would you like to tell someone about this? (Specify) 20. Who hits you or hurts your body? (Specify)			
Comments:			

_____

Employer (participant)

_____

Support Broker

APPENDIX E

Risk Identification Tools

During the Person Centered Planning (PCP) process you may use this tool to facilitate open discussion, analysis, brainstorming, and planning in order to:
1) Identify issues which pose a risk to the participant.
2) Record how the issue is thought or known to be of particular risk to the participant.
3) Determine whether or not the issue of risk should be included on the My Safety Plan.

Below is a list of the most common risk factors. This list is designed to encourage thoughtful discussion about issues of risk which may exist for a particular participant. It is, however, not all inclusive. There may be other potential risks that exist outside of what is listed. Remember, discussing and identifying risk is a critical part of person centered planning. It is what allows a person to live safely and successfully in the community. So take your time with this process and be thorough when thinking about the participant and their needs.

- Eating
- Ambulation
- Transfers
- Toileting
- Communication
- Community Access
- Bathing
- Self-abuse
- Aggression
- Elopement
- Home Maintenance
- Property Destruction
- Use of Restraint
- Psychotropic Medications
- Criminal Behavior
- Sexual Risks
- Poor or Non-Compliance with Medical Regime
- Anticonvulsant Medications
- Skin Breakdown
- Bowel Obstruction
- Nutritional
- Diabetes
- Aspiration
- Cardio/Respiratory
- Orthopedic
- Community Access
- Emergency Response
- Financial Exploitation
- Gastrointestinal
- Injuries
- Falls
- Victimization
- Sensory
- Seizures

What is the issue of risk?	How is this issue thought or known to be of particular risk to this person?	Should this issue be included in the My Safety Plan? Yes/No?

IDAHO DEPARTMENT OF HEALTH & WELFARE

APPENDIX F

Critical Incident Reporting Form

Note: The purpose of this form is for the convenience of participants who wish to report a critical incident in written form. Critical Incidents may also be reported by phone, or in person at the Regional Medicaid Services Office in your area.

Person Reporting Incident

Name:			
Address:	City:	State:	Zip:
Business Name (If Applicable):			
Phone:			

Relationship to Participant (Check One)

☐ Self ☐ Family Member ☐ Other Public Agency ☐ Provider (Traditional)
☐ Guardian ☐ Anonymous ☐ General Public ☐ Provider (Self-Direction)
☐ Advocate ☐ Legislator ☐ Caregiver (Non-Compensated)

Participant Impacted by the Incident

Name:		MID #:	
Address:	City:	State:	Zip:
Phone:			

Other Entity Involved in Incident (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Provider at Time of Incident (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Guardian (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Nature of Incident (Check All That Apply)

☐ Abuse
☐ Death
☐ Neglect
☐ Safety
☐ Exploitation
☐ Serious Injury
☐ Medication Error
☐ Hospitalization
☐ Participant Missing
☐ Other (Specify) _____
☐ Injury Caused by Restraints
☐ Participant Victim of a Crime
☐ Participant Terminates Employee

Check Services that Relate to this Complaint/Issue

Medical	Long-Term Care	Behavioral Health
☐ Dental Services ☐ Durable Medical Equipment (DME) Services ☐ Healthy Connections (HC) ☐ Transportation Services ☐ Other (Specify)	☐ Aged and Disabled (A&D) Waiver Services ☐ Certified Family Homes (CFH) Services ☐ NF Services ☐ RALF Services ☐ Personal Care Services (PCS) ☐ Service Coordination Services ☐ Other (Specify)	☐ Developmental Disability (DD) Waiver (Traditional) ☐ Developmental Disability (DD) Waiver (Self- Directed) ☐ Developmental Disability Agency (DDA) ☐ Service Coordination Services ☐ Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR)Services ☐ Other (Specify)

Description of Incident

_____

_____

_____

_____

_____

Signature: _____

Date Submitted: _____

Complaint Report Form

Note: The purpose of this form is for the convenience of participants who wish to file a complaint in written form. Complaints may also be filed by phone, or in person at the Regional Medicaid Services Office in your area.

Person Reporting Complaint

Name:			
Address:	City:	State:	Zip:
Business Name (If Applicable):			
Phone:			

Relationship to Participant (Check One)

☐ Self ☐ Family Member ☐ Other Public Agency ☐ Provider (Traditional)
☐ Guardian ☐ Anonymous ☐ General Public ☐ Provider (Self-Direction)
☐ Advocate ☐ Legislator ☐ Caregiver (Non-Compensated)

Customer of Concern Information

Name:		MID #:	
Address:	City:	State:	Zip:
Phone:			

Other Customer of Concern Information (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Nature of Complaint (Check All That Apply)

☐ Fraud ☐ Denial of Service ☐ Benefit Amount
☐ Rights ☐ Quality of Care ☐ Confidentiality/Privacy
☐ Referral ☐ Access Issues ☐ Contract Services
☐ Discrimination ☐ Other (Must Specify) _____

Check Services that Relate to this Complaint/Issue

Medical	Long-Term Care	Behavioral Health
☐ Dental Services ☐ Durable Medical Equipment (DME) Services ☐ Healthy Connections (HC) ☐ Transportation Services ☐ Other (Specify)	☐ Aged and Disabled (A&D) Waiver Services ☐ Certified Family Homes (CFH) Services ☐ NF Services ☐ RALF Services ☐ Personal Care Services (PCS) ☐ Service Coordination Services ☐ Other (Specify)	Developmental Disability (DD) Waiver (Traditional) ☐ Developmental Disability (DD) Waiver (Self- Directed) ☐ Developmental Disability Agency (DDA) ☐ Service Coordination Services ☐ Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR)Services ☐ Other (Specify)

Complaint Description

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____

Date: _____

IDAHO DEPARTMENT OF HEALTH & WELFARE

Complaint Intake Worksheet

Note: The purpose of this worksheet is for the convenience of staff taking information on complaints. All complaints are to be entered into the Complaint/Critical Incident SharePoint site within two (2) business days.

Initial Complaint Received by:			
Region:	Phone:	Date:	Time:
Staff Assigned to Investigate Complaint:			

Source of Complaint (Check One)

☐ Self ☐ Family Member ☐ Other Public Agency ☐ Provider (Traditional)
☐ Guardian ☐ Anonymous ☐ General Public ☐ Provider (Self-Direction)
☐ Advocate ☐ Legislator ☐ Caregiver (Non-Compensated)

Person Submitting Complaint (If Other than Customer of Concern)

Name:			
Address:	City:	State:	Zip:
Business Name (If Applicable):			
Phone:			

Customer of Concern Information

Name:		MID #:	
Address:	City:	State:	Zip:
Phone:			

Other Customer of Concern Information (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Nature of Complaint (Check All that Apply)

☐ Fraud	☐ Denial of Service	☐ Benefit Amount
☐ Rights	☐ Quality of Care	☐ Confidentiality/Privacy
☐ Referral	☐ Access Issues	☐ Contract Services
☐ Discrimination	☐ Other (Must Specify) _____	

Check Services that Relate to this Complaint/Issue

Medical	Long-Term Care	Behavioral Health
☐ Dental Services ☐ Durable Medical Equipment (DME) Services ☐ Healthy Connections (HC) ☐ Transportation Services ☐ Other (Specify)	☐ Aged and Disabled (A&D) Waiver Services ☐ Certified Family Homes (CFH) Services ☐ NF Services ☐ RALF Services ☐ Personal Care Services (PCS) ☐ Service Coordination Services ☐ Other (Specify)	Developmental Disability (DD) Waiver (Traditional) ☐ Developmental Disability (DD) Waiver (Self- Directed) ☐ Developmental Disability Agency (DDA) ☐ Service Coordination Services ☐ Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR)Services ☐ Other (Specify)

Complaint Narrative

_____

_____

_____

_____

_____

_____

_____

_____

IDAHO DEPARTMENT OF HEALTH & WELFARE

Critical Incident Intake Worksheet

Note: The purpose of this worksheet is for the convenience of staff taking information on critical incidents. All critical incidents are to be entered into the Complaint/Critical Incident SharePoint site within two (2) business days.

Initial Report Received by:			
Region:	Phone:	Date:	Time:
Staff Assigned to Investigate Incident:			

Source of Report (Check One)

☐ Self ☐ Family Member ☐ Other Public Agency ☐ Provider (Traditional)
☐ Guardian ☐ Anonymous ☐ General Public ☐ Provider (Self-Direction)
☐ Advocate ☐ Legislator ☐ Caregiver (Non-Compensated)

Person Reporting Incident (If Other than Victim of Incident)

Name:			
Address:	City:	State:	Zip:
Business Name (If Applicable):			
Phone:			

Victim Information (Participant Impacted by the Incident)

Name:		MID #:	
Address:	City:	State:	Zip:
Phone:			

Alleged Perpetrator Information or Other Entity Involved in Incident (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Provider at Time of Incident (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Guardian (If Applicable)

Name:	MID#: (If Applicable)	Provider #: (If Applicable)	
Address:	City:	State:	Zip:
Phone:			

Nature of Complaint (Check All that Apply)

☐ Fraud ☐ Denial of Service ☐ Benefit Amount
☐ Rights ☐ Quality of Care ☐ Confidentiality/Privacy
☐ Referral ☐ Access Issues ☐ Contract Services
☐ Discrimination ☐ Other (Must Specify) _____

Check Services that Relate to this Complaint/Issue

Medical	Long-Term Care	Behavioral Health
☐ Dental Services ☐ Durable Medical Equipment (DME) Services ☐ Healthy Connections (HC) ☐ Transportation Services ☐ Other (Specify)	☐ Aged and Disabled (A&D) Waiver Services ☐ Certified Family Homes (CFH) Services ☐ NF Services ☐ RALF Services ☐ Personal Care Services (PCS) ☐ Service Coordination Services ☐ Other (Specify)	Developmental Disability (DD) Waiver (Traditional) ☐ Developmental Disability (DD) Waiver (Self- Directed) ☐ Developmental Disability Agency (DDA) ☐ Service Coordination Services ☐ Intermediate Care Facility (for Developmentally Disabled)/Mentally Retarded (ICF/MR)Services ☐ Other (Specify)

Description of Incident

_____

_____

_____

_____

_____

_____

_____

_____

Date Referred to Outside Agency (If Applicable): _____

Name of Agency: _____

Name of Contact: _____

Phone Number: _____

IDAHO DEPARTMENT OF HEALTH & WELFARE

APPENDIX G

Waiver of Criminal History Check

Background

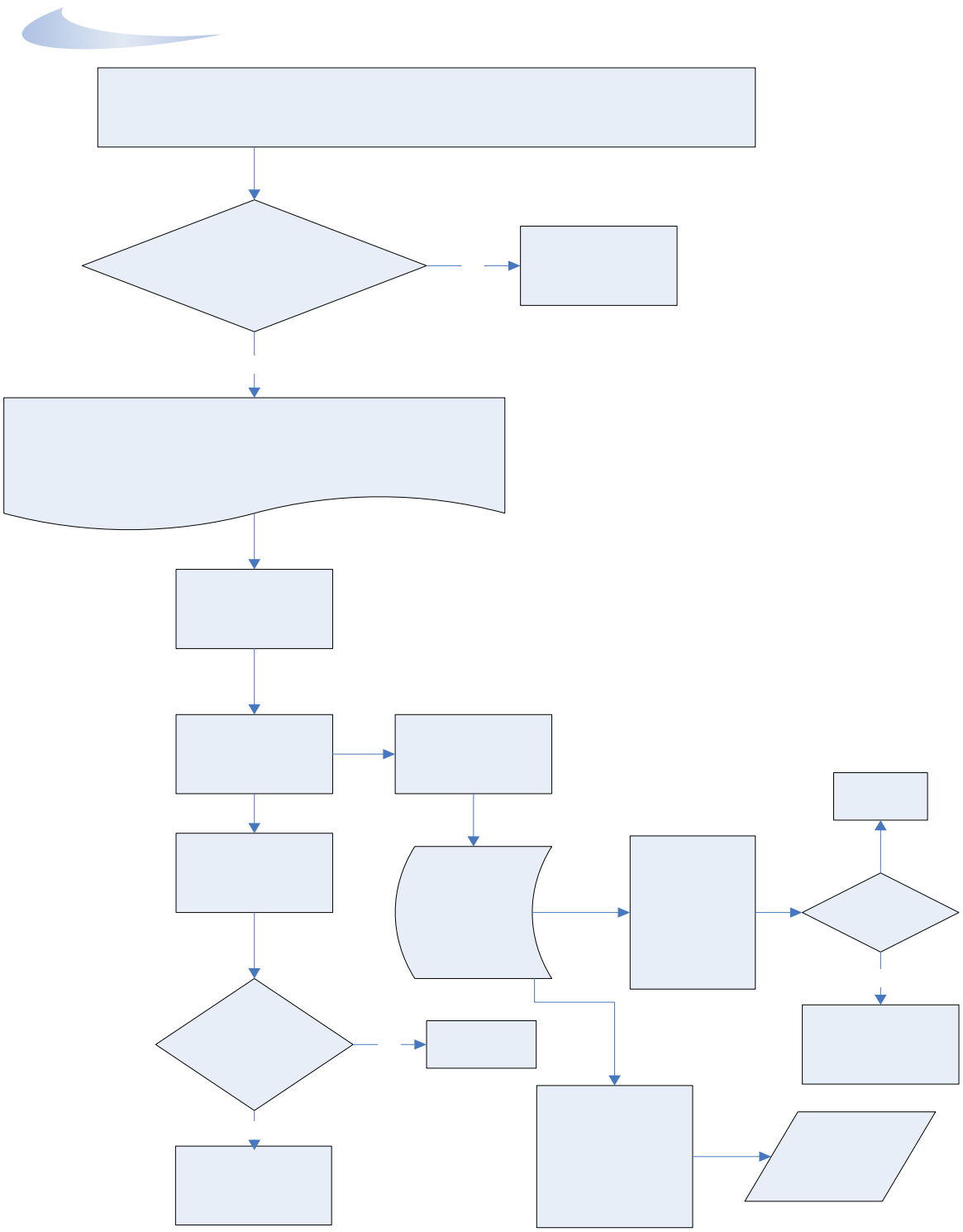
Self-direction under a Home and Community Based Services Waiver is based on the premise that participants should be able to make decisions and accept the risks associated with those decisions. This concept can at times be at cross purposes with waiver assurances that are required by CMS. Waiver assurances in areas such as participant Safeguards and Qualified Providers must still be met by States.

The decision was made by Idaho to allow participants to waive the criminal history check for a Community Support Worker under certain conditions (Idaho Administrative Procedures Act (IDAP) 16.03.13.150.01.a).

Policy

- Participants who choose to waive the criminal history check for a Community Support Worker must indicate that they are choosing to waive the requirement on the Employment Agreement with the worker.
- The participant and guardian (if applicable) must complete and sign the Waiver of Liability – Assumption of Risk form which states that they understand the risks of waiving this requirement.
- The Waiver of Liability – Assumption of Risk form must include:
  - The rationale for waiving the requirement.
  - Information on how they will assure that they are not at risk for abuse, neglect, or exploitation as a result of waiving the criminal history check.
  - Verification by the Support Broker that they have provided education and counseling regarding the risk of waiving the criminal history check to the participant and guardian (if applicable).
- The Support and Spending Plan must address how risks of waiving the criminal history check will be addressed.
- Concurrent Reviews will include a random sample of participants who have waived the criminal history check for a Community Support Worker.
- The Fiscal Employer Agent sends copies of all criminal history check waivers to Regional Medicaid Services quarterly.
- Regional Medicaid Services:
  - Enters a participant tickler regarding the waiver into the Regional Medicaid Services database.
  - Runs a report from the Complaint/Critical Incident Reporting Application quarterly against the list of participants with a Community Support Worker with a waived criminal history check.

Process Flow



Procedures

1. During the Self Assessment Process, risks for abuse, neglect, and exploitation are assessed. If the participant, their Support Broker, or their circle of supports identifies a risk in one or more of these areas, the Support and Spending Plan must address the supports needed to protect the participant from the risk(s). If known, the plan must address the planned waiver of a criminal history check for any planned Community Support Workers.

2. At the time the participant hires a Community Support Worker and chooses to waive the criminal history check, the participant must indicate that they are waiving the requirement on the Employment Agreement and complete the Release of Liability form. This form must be included in the employment package sent to the Fiscal Employer Agent.

3. The Fiscal Employer Agent must keep a tickler file of all Employment Agreements with criminal history check waivers and make it available to the Department upon request.

4. The Fiscal Employer Agent will check the criminal history sanction list from the Bureau of Audits and Investigations prior to completing the approval process for a Community Support Worker with a waived criminal history check. If the provider is on one of the lists, the participant and/or their family/guardian and the Regional Medicaid Services is informed and the Employment Agreement is not approved.

5. The Fiscal Employer Agent will send the Regional Medicaid Services copies of criminal history check waivers quarterly.

6. Regional Medicaid Services will conduct a search of the complaint/critical incident tracking system for any complaints or incidents associated with the participants and Community Support Workers who have a waiver. If complaints have been received, counseling will be provided to the participant regarding the waiver of the criminal history check. If problems are identified participant will be scheduled for a concurrent review.

7. Concurrent reviews will include a sampling of participants who have waived the criminal history check for their community support worker.

8. Regional Medicaid Services will submit annual reports to Central Office regarding:
   - Number of waivers.
   - Problems/issues because of waivers.

9. Quality Oversight Reports to the Quality Oversight Committee will include an analysis of the impact of this waiver process.

Legal Guardians as Paid Caregivers

Policy

It is the intent of the Division of Medicaid to allow legal guardians to be a paid Community Support Worker under the Self-Directed Waiver Option of the Developmental Disabilities Home and Community Based Services Program. A legal guardian can be paid to provide the supports identified on the Support and Spending Plan with the exception of the following:

- A Legal Guardian cannot be paid to fulfill the responsibilities the participant agrees to under the “Agreement to Select Self-Directed Services”.
- A Legal Guardian cannot be paid to fulfill the responsibilities they are legally responsible to fulfill, as ordered in the guardian/conservator court order(s).

The Department will take measures to prevent a conflict of interest and unfair financial gain by a legal guardian who is hired by a participant as a Community Support Worker. Guardian/Conservator court orders must be submitted with the Support and Spending Plan.

When a participant's legal guardian has been selected to provide community support services for a Self-Directed participant, the following authorization criteria and monitoring provisions must be in place:

Authorization Criteria

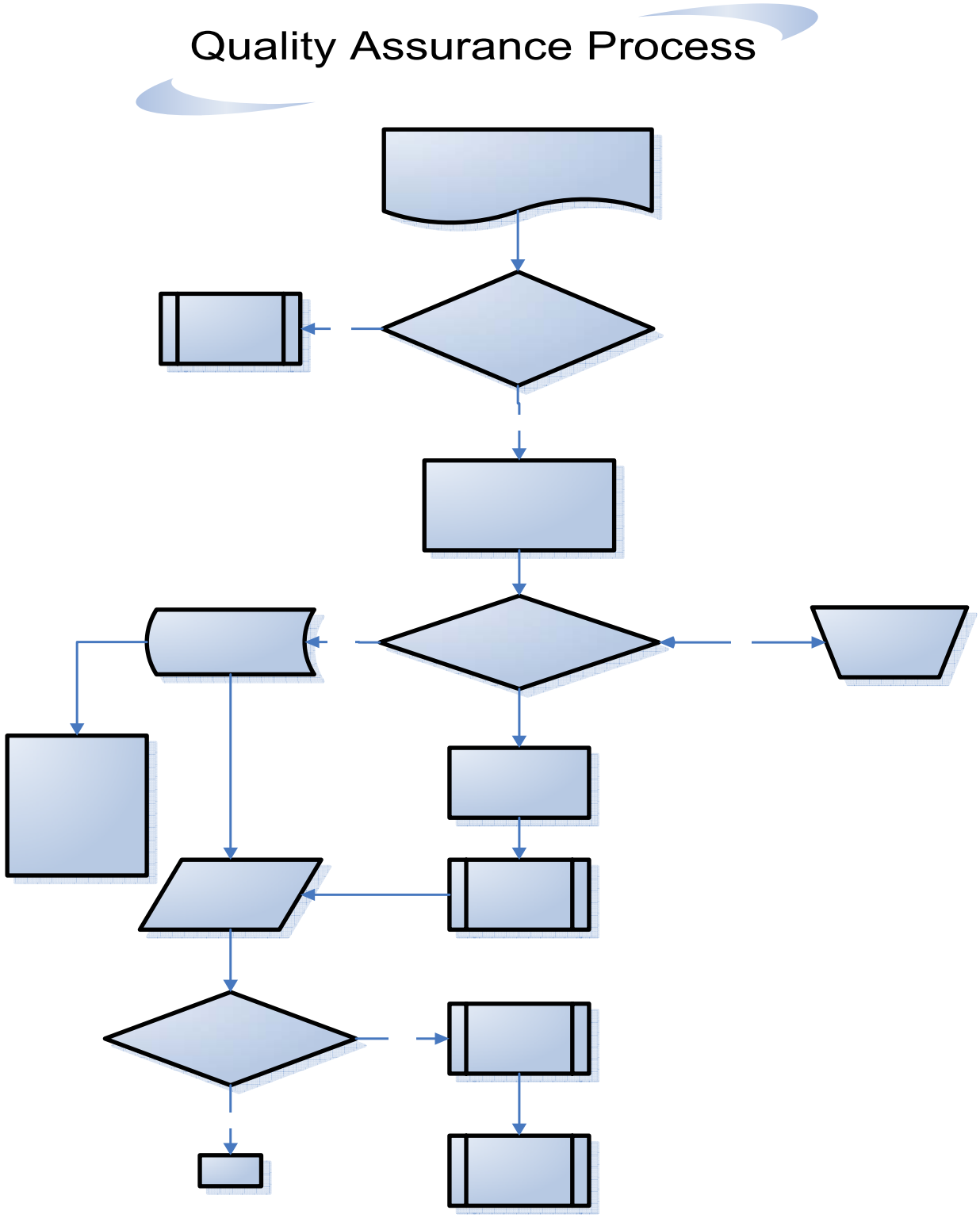
- The service must meet the definition of a community support as listed in IDAPA 16.03.13.110, *Paid Self-Directed Community Supports*.
- The service must be a service that is authorized in the Support and Spending Plan.
- The service must be paid at a rate that does not exceed that which is customary in the geographic area for similar services.
- If the participant lives in a Certified Family Home with the legal guardian, the Community Support Worker services cannot duplicate the services expected under the room and board payment (rent, utilities, food, etc) that is paid through the participants Aid to the Aged, Blind, and Disabled supplement or SSI in accordance with Certified Family Home Rules.
- The Circle of Support for a participant, who hires a legal guardian, must include at least one non-family member in addition to the Support Broker. A family member for purposes of this provision includes any person related by blood or marriage to the participant or legal guardian.

Monitoring Strategies

In addition to monitoring and reporting activities required for all Self-Directed processes and activities, the following additional monitoring activities are required when the participant elects to use a legal guardian as a paid provider.

- Quarterly quality assurance/quality improvement reviews (criteria to be developed) by the Support Broker (submitted to the Department, and to include such things as Health and Safety; verification that services are being delivered as documented on the timesheets).
- Concurrent review when needed.

Process



Follo
Defin
Authoriz
Proce

Procedures

1. Support and Spending Plans, where a legal guardian is identified as a paid Community Support Worker, are reviewed with the prior authorization criteria listed in this policy in addition to any other prior authorization criteria.

2. If the criteria are not met, the Support and Spending Plan is returned to the Support Broker for modification.

3. Approved Support and Spending Plans, where a paid Community Support Worker is a legal guardian for the participant, are flagged in the Regional Medicaid Services data base for follow up.

4. The Support Broker and the Fiscal Employer Agent are advised of quality assurance/quality improvement responsibilities.
   - Support Broker - Quarterly review of plan and services provided.
   - Fiscal Employer Agent - Quarterly review of time sheets.

5. On a quarterly basis a report of participants with a Legal Guardian as a Community Support Worker are pulled by the quality assurance/quality improvement staff from the Regional Medicaid Services database. The list is compared with the following:
   - Quality assurance/quality improvement reviews from the Support Broker and Fiscal Employer Agent review of expenditures.
   - When potential problems are identified through the quality assurance reviews, the participant is identified for a concurrent review process.

6. On-going concurrent reviews include a random sample of participants who have legal guardians as paid Community Support Worker's.

7. Actions are taken as appropriate.

Complaint/Critical Incident Reporting

Policy

The intent of this policy is to define a process to deal with complaints and critical incidents that compromise the safety or the quality of services to Medicaid participants, and to identify a process to report abuse, neglect, exploitation, and Medicaid fraudulent transactions to the appropriate investigative authority. Complaints or incidents of abuse, neglect, or exploitation that are referred to Adult Protections must also be tracked in the complaint/critical incident reporting SharePoint application.

The complaint/critical incident reporting processes are the avenues by which a Medicaid participant applying for, or receiving Home and Community Based Services, or a complaint/critical incident person:

- Registers dissatisfaction with, or reports problems with, one or more of the following:
  - Access Issues – Issues involving the availability of services, barriers to obtaining services, or lack of resources/services.
  - Benefit amount – A disagreement by a participant regarding the amount of benefits that they received.
  - Confidentiality – Issues dealing with legal obligations regarding the Department's responsibility to protect a participant's personal information. Keeping participant information confidential is the responsibility of the Department.
  - Contract services – Issues involving an entity providing services under a contract with the Department. (Does not include providers of services under Medicaid Provider Agreements.)

    - Denial of service – The denial by the Department to provide or reimburse for a service or program requested by a participant or his/her representative.
    - Discrimination – The prejudicial treatment of participants protected under federal and/or state law (includes any form of discrimination based on race, color, gender, national origin, age, religion, or disability).
    - Fraud – An intentional deception or misrepresentation made by a person with knowledge that the deception could result in some unauthorized benefit to him/herself or some other person according to IDAPA 16.03.09.201.05.
    - Privacy – Issues dealing with the right of participants to access and control their personal information and not have it used or disclosed by others against their wishes.
    - Referrals – Issue or complaint/critical incident dealing with the ability of a provider or participant to obtain a referral to a provider other than the assigned Healthy Connections Primary Care Provider.
    - Quality of Care – Issues that involve the meeting or not meeting of rules, policies, or commonly accepted practice standards around care/services provided to participants of the Department.
    - Other – When the complaint does not fit one of the classifications listed, this classification may be used, and must describe the complaint/critical incident.
- Reports one or more of the following critical incidents:
    - Abuse – The non-accidental infliction of physical pain/injury or mental injury.
    - Exploitation – An action which may include, but is not limited to, the misuse of a vulnerable adult's funds, property, or resources by another person for profit or advantage, (Idaho Code, 39-5302; 7).
    - Death of a participant regardless of the cause or location.
    - Hospitalizations.
    - Injury caused by restraints.
    - Medication error that results in the need for medical care or a pattern of medication errors.
    - Neglect/Safety Issues – Failure of a caretaker to provide food, clothing, shelter, or medical care reasonably necessary to sustain the life and health of a vulnerable adult, or the failure of a vulnerable adult to provide those services for himself, (Idaho Code 39-5302; 8).
    - Participant is missing, and missing persons report has been filed.
    - Participant is the victim of a crime.
    - Self Advocate termination of an employee for a criminal conviction or substantiated adult or child protection claim.
    - Serious injury that results in a need for care beyond first aide.
    - Violation of rights.

All complaint/critical incidents regarding the provision of Home and Community Based Services will be investigated and tracked in the complaint/critical incident reporting SharePoint application. Appropriate safeguards will be provided to assure the health and safety of participants.

Complaints/Critical Incidents are not:

- Program inquiries.
- Problem solving where the receipt of the correct information satisfies the submitter's complaint/critical incidents.
- Requests for information.
- Complaint/critical incidents beyond the jurisdiction of the Department that are referred immediately to the appropriate agency.
- Legal actions other than appeals.
- Employee specific issues - Refer employee specific complaint/critical incidents to the appropriate supervisor or program management.
- Information or referrals.

Response Time Frames

It is critical that complaint/critical incidents are dealt with in an expedient manner, to include timely and legal reporting to authorities, standard investigation, documentation procedures, and follow-up activities.

Priority one

There is an immediate health or safety issue or other program criteria defined by participant program protocols that have been met:

- Must be responded to within four (4) hours.
- May result in an interim resolution/response until a permanent resolution/response can be accomplished.

Priority two

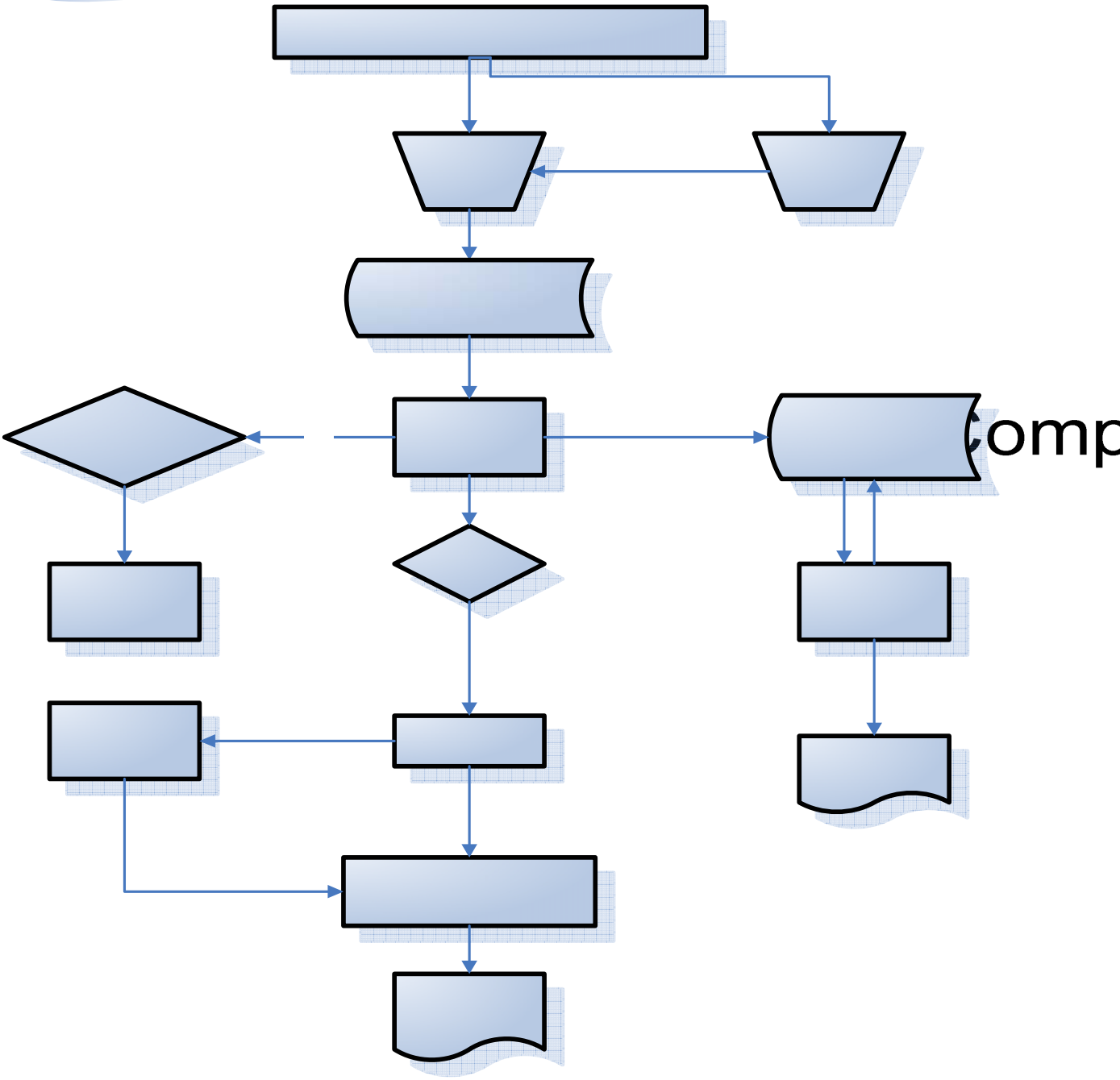
There is not an immediate health or safety issue.

- Follow Department customer service standards for response times on phone calls, letters, etc.

Priority three

Resolution/response time frames for a specific type of complaint/incident are defined in rule or law.

Process



Procedures

1. The Regional Medicaid Services or Medicaid Central Office personnel may receive a complaint, or information regarding a critical incident from a variety of sources including but not limited to:
   - Medicaid Recipients, family members, friends, and representatives.
   - Medicaid Provider Assistance Agencies.
   - Hospitals, health care agencies, and professionals.
   - Nursing homes, RALFs, and certified family homes.
   - Health and Welfare Programs and other State of Idaho agencies.
   - Out of state.
   - Anonymous.
   - Other.

2. When a complaint or critical incident report that meets the definition in the above stated policy is received by the Regional Medicaid Services, the "Point of Contact Person" will enter the information into the complaint/critical incident reporting SharePoint application.
   a) If the critical incident alleges there is reasonable cause to believe abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health, or safety of a vulnerable adult, the Point of Contact Person will immediately, or at least within four (4) hours, notify the appropriate law enforcement authority, Adult Protection, and/or Child Protection, (Idaho Statute 39-5303, Adult Abuse, Neglect, and Exploitation Act, Addendum 2).

3. The Program Manager is responsible to ensure all complaint/critical incidents are promptly assigned to the appropriate staff person or unit for investigation and resolution. Additional considerations might include:
   a) If the complaint/critical incident report requires no future action or staff assignment, final information will be recorded in the complaint/critical incident reporting SharePoint application.
   b) Depending on the nature of the complaint/critical incident report, the Program Manager may wish to notify the Division of Medicaid Deputy Administrator, Regional Director, Facility Standards, or Bureau of Audits and Investigations, and follow-up with law enforcement, child protection, and/or adult protection.

4. The Staff person or unit assigned to investigate and resolve complaint/critical incident may:
   a) Conduct person to person, telephonic or on-site investigation processes.
   b) May work collaboratively with other agencies to investigate complaint/critical incident.
   c) May request written reports and documentation from various parties.
   d) Will advise the Program Manager when additional resources or staff is needed to assist with an investigation.
   e) Will report abuse, neglect, and exploitation, if discovered, to appropriate authority within required time frame, (Idaho Statute 39-5303, Adult Abuse, Neglect, and Exploitation Act, Addendum 2).
   f) Will strictly comply with all confidentiality laws and rules.

5. Upon resolving a complaint/critical incident or investigation of a critical incident the assigned staff person or unit will complete all documentation on the SharePoint site, notify appropriate agencies, and notify the Program Manager of results and findings. Additionally:
   a) The Program Manager may notify the Division of Medicaid Deputy Director, Regional Director, Facility Standards, Bureau of Audits and Investigations, and/or Deputy Attorney General of investigation finds and resolution.
   b) The Program Manager may require that investigating staff person or unit expand investigation or take additional action.
   c) If Medicaid Fraud was substantiated, the Program Manager will notify the Bureau of Audits and Investigations using procedure established in IDAPA 16.03.09.200-211.

Idaho Department of Health & Welfare
Authorization for Disclosure

Please complete and return this form to a Department of Health and Welfare office.

Available in Spanish. We provide interpreter services at no cost. Call 2-1-1 or (800) 926-2588 for interpretation assistance. Disponible en espanol. Proveemos servicios de intérprete sin costo alguno. Llame al 2-1-1 ó al (800) 926-2588 para obtener la ayuda de un intérprete.

Participant Information

Participant Name _____ Date of Birth _____
(First, MI, Last)

Telephone _____

Mailing Address _____ State _____ Zip Code _____

Requestor Information
(To be completed if authorization is being made by someone other than the subject of the information. Please provide documentation of your authority).

Requestor Name (If different than Participant) _____ Telephone _____

Mailing Address _____ State _____ Zip Code _____

Authorization Details
I authorize the following participant, organization, or business

_____

to disclose my confidential information to:

Name _____

Mailing Address _____ State _____ Zip Code _____

For the purpose of:

_____

Please describe in detail the information to be disclosed:

_____

_____

_____

This authorization will expire in six (6) months unless another date or event is specified here.

I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to a Department of Health and Welfare. I understand that the person or entity who receives my confidential information may not be required to prevent unauthorized use or disclosure.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV infection, alcohol and/or drug abuse, and mental health conditions.

I understand that my signature on this form is not required for treatment, payment, enrollment, or eligibility for benefits, and that a copy of this authorization shall be as valid as the original.

_____

Your signature **Date**

Your signature must be notarized if we are unable to verify your identity and you must submit this request by mail.

APPENDIX H

Fiscal Employer Agent Forms

The forms supplied by Acumen are unavailable at the time of this printing. They will be included in a future revision. In the meantime, contact the Regional Care Manager for the specific forms.

APPENDIX I

Support Broker Application

You must complete all parts of the application. An incomplete application, or an application that does not clearly show the experience or training required, will not be accepted. If you have no information to enter in a section, please write N/A.

Submit the completed application to:
Idaho Department of Health and Welfare Regional Medicaid Services
Bureau of Developmental Disability Services
Attn: Mellie Turrittin
3402 Franklin Road
Caldwell, ID 83605

The Division of Medicaid will notify you after your "Support Broker Application" is reviewed.

Name and Address	
Name (First, MI, Last)	Social Security Number
Mailing Address	
City, State, and Zip Code	
Home Phone	Cell Phone
E-mail Address	May we use e-mail to contact you? Yes □ No □

Additional Information
The minimum age to qualify to be a support broker is 18. Please attach a copy of driver's license, birth certificate, or other document to verify your age. I certify that I am 18 years of age or older. **Signature**:_____
I understand that I must pass a criminal history background check for the Idaho Department of Health and Welfare or must have been granted an exemption from the Criminal History Unit in order to become a qualified support broker. **Signature**:_____ I am interested in providing support broker services to participants in the following towns, cities, or rural areas (please write in the towns, cities, and rural areas you want to serve): _____

Education			
High School	From	To	Did you graduate?
Continuing Education Please list any colleges attended, coursework taken, and vocational or certification training			
Location		Type of degree or diploma	
School	From	To	Did you graduate?
Location		Type of degree or diploma	
School	From	To	Did you graduate?
Location		Type of degree or diploma	
School	From	To	Did you graduate?
Location		Type of degree or diploma	
School	From	To	Did you graduate?

Relevant Work History List any jobs held that illustrate at least two years verifiable experience with the target population.				
Job Title	From	To	Hrs./Week	Employer
Address	Phone	Supervisor		May we contact this employer? Yes □ No □
Job Responsibilities				

Job Title	From	To	Hrs./Week	Employer
Address	Phone	Supervisor		May we contact this employer? Yes □ No □
Job Responsibilities				

Job Title	From	To	Hrs./Week	Employer
Address	Phone	Supervisor		May we contact this employer? Yes □ No □
Job Responsibilities				
Please list additional relevant training, coursework, skills, or knowledge				

I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, my application may be rejected and my qualification to provide services as a support broker may be terminated by the Idaho Department of Health and Welfare, Division of Medicaid.	
Signature	**Date**

Background Check Clearance

You must complete an Idaho Department of Health and Welfare (IDHW) criminal history background check.

Criminal history applications are submitted on the Web at: **www.chu.dhw.idaho.gov**.

- Toll-free phone number: (800) 340-1246
- Boise phone number: 332-7990
- E-mail: **crimhist@dhw.idaho.gov**.

The fee for the IDHW criminal history background check is **$48.00**.

During the on-line criminal history application, you will be asked to enter the employer identification number. **Enter 1710,** to identify your background check for support broker.

Criminal history clearance is typically completed three to seven days after fingerprinting. When it is complete, an e-mail notice will be sent to the Division of Medicaid, Bureau of Develpmental Disability Services.

If you receive a conditional denial because of disclosures you made or information received by the Criminal History Unit during the background check process, an exemption must be granted before you will be able to receive a final background check clearance. You have 14 days to request an exemption hearing.

Denial of Application

If your application does not demonstrate that you possess the minimum qualifications, knowledge, skills, or experience required to be a support broker, you will be sent a letter denying your application. The letter of denial will contain information regarding your right to appeal the department's decision to deny the application. **Your application will be denied if you do not clear the criminal history background check.**

Approval of Application

If your application is approved, you will be sent a letter with information regarding training and the qualifying support broker exam. Although training will be available, you are not required to take it. However, you will be tested and held responsible for knowing the information contained in the training. This exam is designed to evaluate your comprehensive understanding of the principles and practices associated with self-direction. A minimum score of 70 is required to pass the exam.

Your acceptance letter will contain information regarding training and scheduling your exam.